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VOLUME [illegible] JANUARY 1970 NUMBER 1

The Journal of The KENTUCKY Medical Association



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KMA INTERIM MEETING
April 8-9
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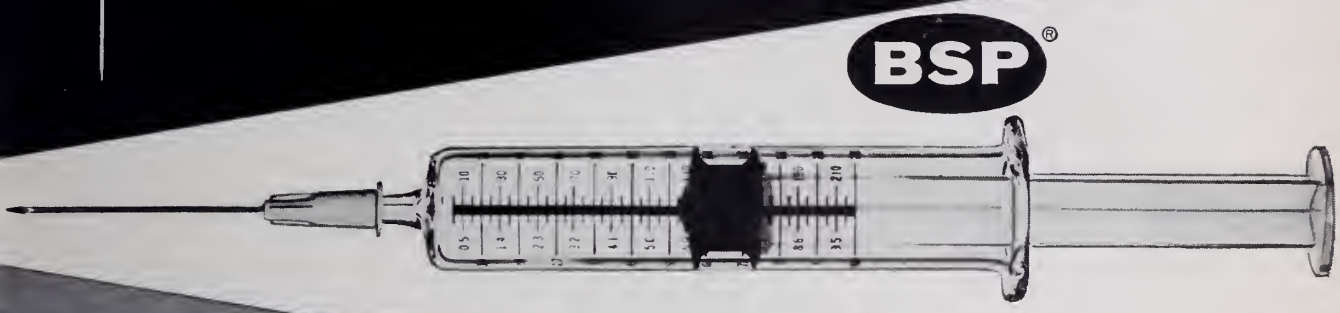
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Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

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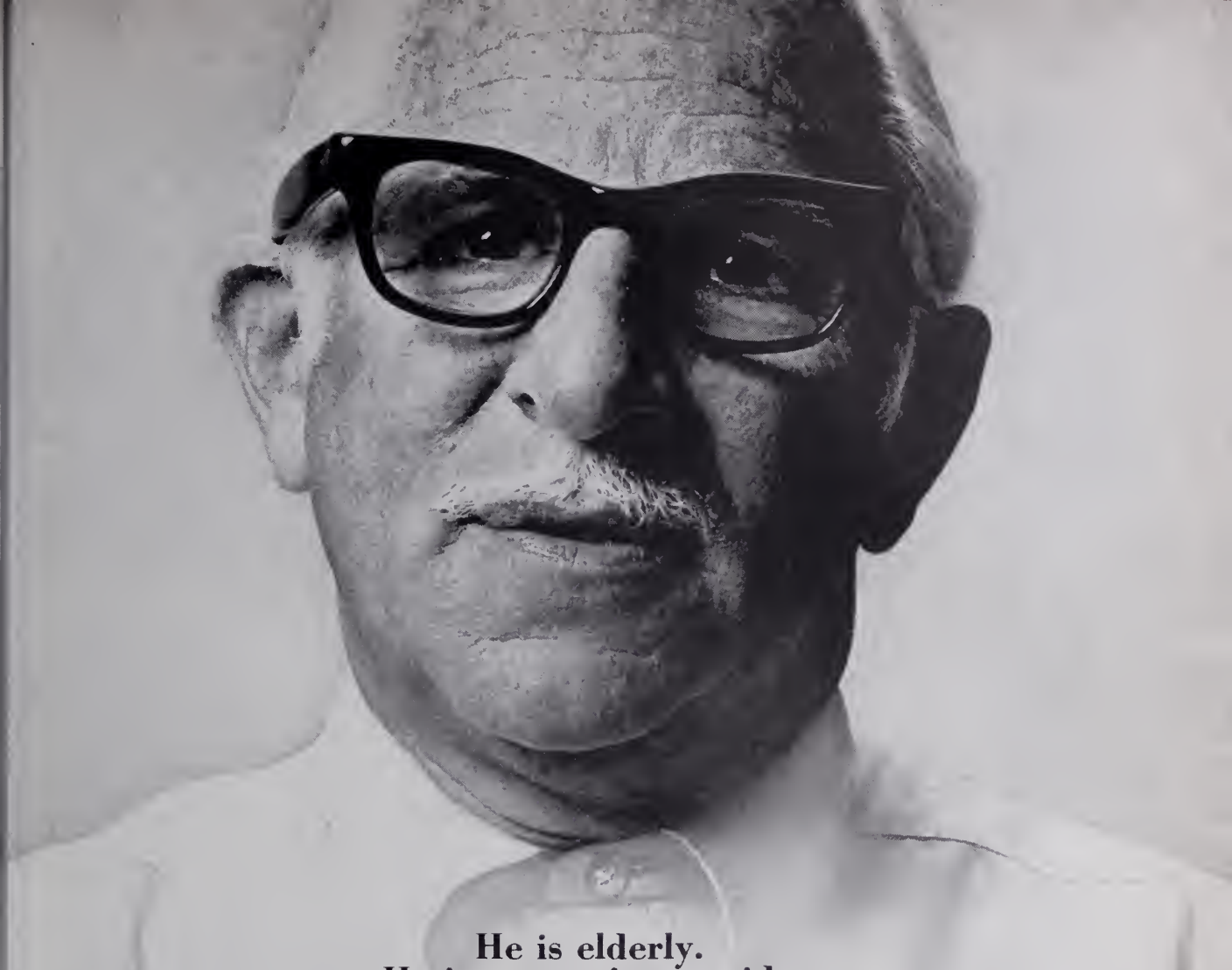
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ntraindication: History of hypersensitivity to demethylchlortetracy-ne or nystatin.

arning: In renal impairment, usual doses may lead to excessive accum-ation and liver toxicity. Under such conditions, lower than usual doses e indicated, and, if therapy is prolonged, serum level determinations ay be advisable. A photodynamic reaction to natural or artificial sun-ght has been observed. Small amounts of drug and short exposure may oduce an exaggerated sunburn reaction which may range from ery-ema to severe skin manifestations. In a smaller proportion, photo-ergic reactions have been reported. Patients should avoid direct posure to sunlight and discontinue drug at the first evidence of skin scomfort. Necessary subsequent courses of treatment with tetracy-nes should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MESSAGE FROM THE PRESIDENT



Is Your Wife's Slip Showing?

Could this be a reference to your wife's lingerie?

Many of your wives are making a noteworthy and substantive contribution to our profession and Kentucky. They attend schools, universities and colleges, teach Sunday School, act as Scout leaders, work on community projects and yes, also work in your offices. Let us justly applaud them for such efforts that serve all in each community.

Why then do we talk about slips' showing? It's about membership.

Auxiliary by definition means to give or furnish aid and to compliment or supplement. Most of the missions of the Woman's Auxiliary to Kentucky Medical Association are to extend the horizons of the Kentucky Medical Association. We do this by cultivating friendly relations and understanding among physicians families, and by participating in the many endeavors of the Kentucky Medical Association at their request.

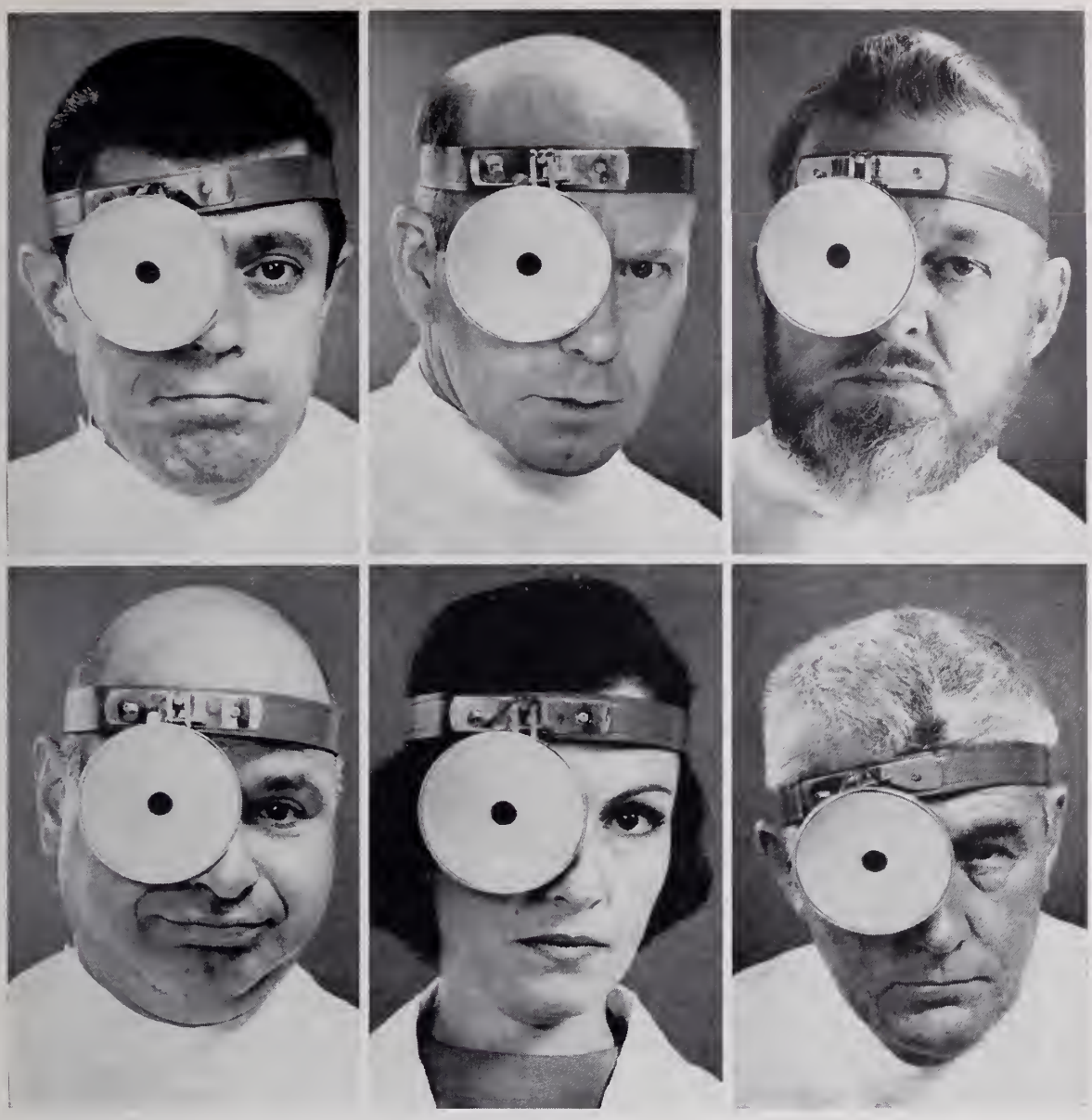
In this complicated life of Medicare, Medicaid, total care, utilization, batch numbers and you know the rest, we want and we must cling together (KMA and WA-KMA); in fact, we must embrace one another fervently. We truly want to aid and assist you and be your strong right arm in this challenging life.

While a proportionate number of your wives belong to the Auxiliary, we need them all and we need your support. Now, how about you checking with your wife and seeing if her slip is showing. If it is, will you help us correct this by helping her become a member?

If you don't, maybe its your slip that is showing!

Mrs. Hoyt D. Gardner, President
Woman's Auxiliary to Kentucky Medical Association

This is the second in a series of articles written at the request of KMA President Walter L. Cawood, M.D



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

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So next time you hear someone say that *all* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.



From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 9-68. This 18-year-old married white female was seen in the physician's office on May 11, 1968, with the history of having abdominal cramps and vaginal bleeding that began the previous day. Last menstrual period was in January. She gave no history of having seen any other physician prior to this visit. She denied any serious illness and had no previous surgery or allergies.

Examination revealed the patient quite pale, with marked edema of both lower extremities. She had signs of air hunger. The uterus was enlarged to 24 to 26 week size. Vaginal examination revealed dark blood in the cervical os. She was advised to be hospitalized for further study.

On admission to the hospital she appeared markedly pale with auricular tachycardia, her pulse was 110, blood pressure 100/50, lungs were clear. The uterus was enlarged just above the umbilicus and seemed to be contracting, no fetal heart tone could be heard. No note was made of cervical dilatation. Her hematocrit on admission was 22 per cent, with 6.8 gram hemoglobin. A consultant saw the patient and after examination described her condition as poor. He suggested blood transfusion and re-evaluation when her condition improved.

She was taken to the operating room, given IV Pentothal, and a D and C was done. Examination revealed the cervix small and a bulging mass was found in the pouch of Douglas. Examination by another physician concurred the patient was pregnant. The uterus was sounded 8 cm. before resistence was met. A ring forceps was inserted, no amniotic fluid escaped, small threads of what appeared to be decidual tissue were removed. The patient became markedly cyanotic. The procedure was terminated until her condition improved. She was intubated and given oxygen to improve the marked cyanosis. Blood was started at 5:15 p.m. She was placed in Trendelenburg's position and continued to have marked cyanosis in spite of endotracheal oxygen.

While the blood transfusion was running she seemed to develop pulmonary edema. She received Mercuhydrin, and was digitalized. Her cyanosis never cleared. She failed to arouse, her bright red blood that filled the lungs and the abdomen became distended. "She apparently had heart failure due to anemia apparently secondary to permature separation of the placenta four to five days duration." She expired at 9:10 p.m., May 11, 1968.

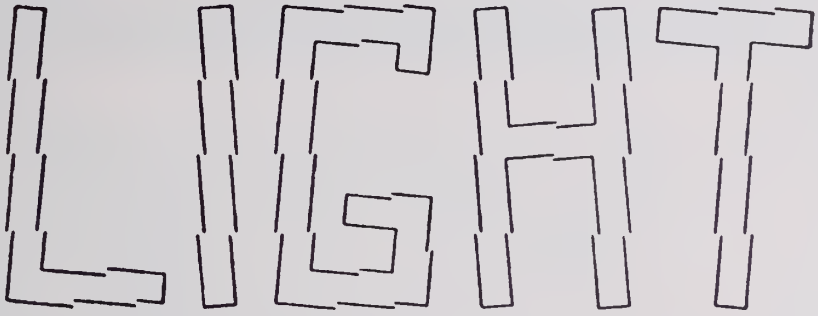
Comment

The Committee had considerable difficulty rendering a decision in this case from the information submitted. However, a number of preventable factors are clearly evident and contributed to the patient's demise.

A proper diagnosis was never established, but the patient might have suffered from unrecognized cardiac disease. No mention is made of chest and abdominal x-rays which would have constituted the minimum of pre-operative investigation. The Committee considered the decision for dilatation and curettage of a uterus 24 weeks gestation size most inappropriate. It was clearly unwise to administer anesthesia prior to adequate blood replacement. Hypoxia obviously occurred during anesthesia and there appeared to be delay in establishing a proper air-way. The volume and nature of intravenous fluids and the rate of blood transfusion are not recorded but these apparently precipitated pulmonary edema.

It was difficult to interpret the statement ". . . bright red blood that filled the lungs. . ." but the abdominal distension reported was likely due to severe intraperitoneal hemorrhage. In view of the statement that the uterus sounded only to eight centimeters the possibility of an abdominal pregnancy should be considered, or conceivably some other intraperitioneal accident occurred producing fatal hemorrhage. Also since no autopsy was performed a definite diagnosis of pregnancy has not been established. It is conceivable that a condition other than a complication of pregnancy occurred.

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PUBLIC HEALTH PAGE

Standards for Nursing Homes and Licensure of Nursing Home Administrators †

Russell E. Teague, M.D., M.P.H.

Commissioner of Health

Commonwealth of Kentucky

THE impact of present day assistance and insurance programs has placed great emphasis on quality patient care. Standards commensurate with patient needs and requirements have been developed, established and implemented in order that the nursing home or extended care patient may be assured of high quality patient care when this level of institutional care is prescribed by the physician as a continuing rehabilitation measure following acute hospital care.

The individual charged with the responsibility of the planning, organizing, directing and controlling the operation of a nursing home and who in reality functions in this capacity is the administrator.

The degree, then, to which current standards of patient care are effected within any nursing home, depends largely upon the training and competency of the administrator and his sincerity and skill in performing his assigned tasks with the assistance of an adequate and qualified dedicated staff.

In 1967, enabling legislation, which was made a part of the Social Security Act by amendment, was enacted by the Congress requiring that by July 1, 1970, each state desiring to receive federal contributions toward the costs of medical assistance programs under Title XIX of the Social Security Act must have in operation a plan for the licensure of the administrators of nursing homes. Therefore, each state participating in Title XIX must adopt administrator licensing legislation no later than July 1, 1970, and licensure procedures and regulations must be effective by July 1, 1970.

Each state is charged with the responsibility of enacting legislation in accordance with and supporting the enabling federal legislation. Mindful of the urgency in developing and pursuing a course of action in this endeavor, several months ago an ad hoc committee on the Study of Legislation for Licensure of Nursing Home Administrators was appointed to review the licensing laws of our sister states and to seek appropriate legislation for our own Commonwealth.

The ad hoc committee is composed of seven persons knowledgeable and well versed in standards of nursing home care. This committee has been diligent not only in researching the past and proposed legislation of other states, but also in looking ahead to educational programs for those individuals presently serving in the capacity of nursing home administrator who will desire or require at least seminar instruction and preparation prior to writing an examination to qualify as an administrator on or before the designated date. Plans for continuing educational programs in this field are being developed, and at an early date it is expected that many colleges and universities will cooperate with federal agencies in the development of a suitable curriculum for the training and education of nursing home administrators. These training programs will most assuredly be structured to better prepare the nursing home administrator to direct his efforts toward the high quality patient care so essential to the welfare of the patient.

†*This article was prepared by: Eva M. Jarvis, Principal Administrative Analyst, Medical Care Standards Program, Kentucky State Health Department, 275 East Main Street, Frankfort, Kentucky 40601*



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

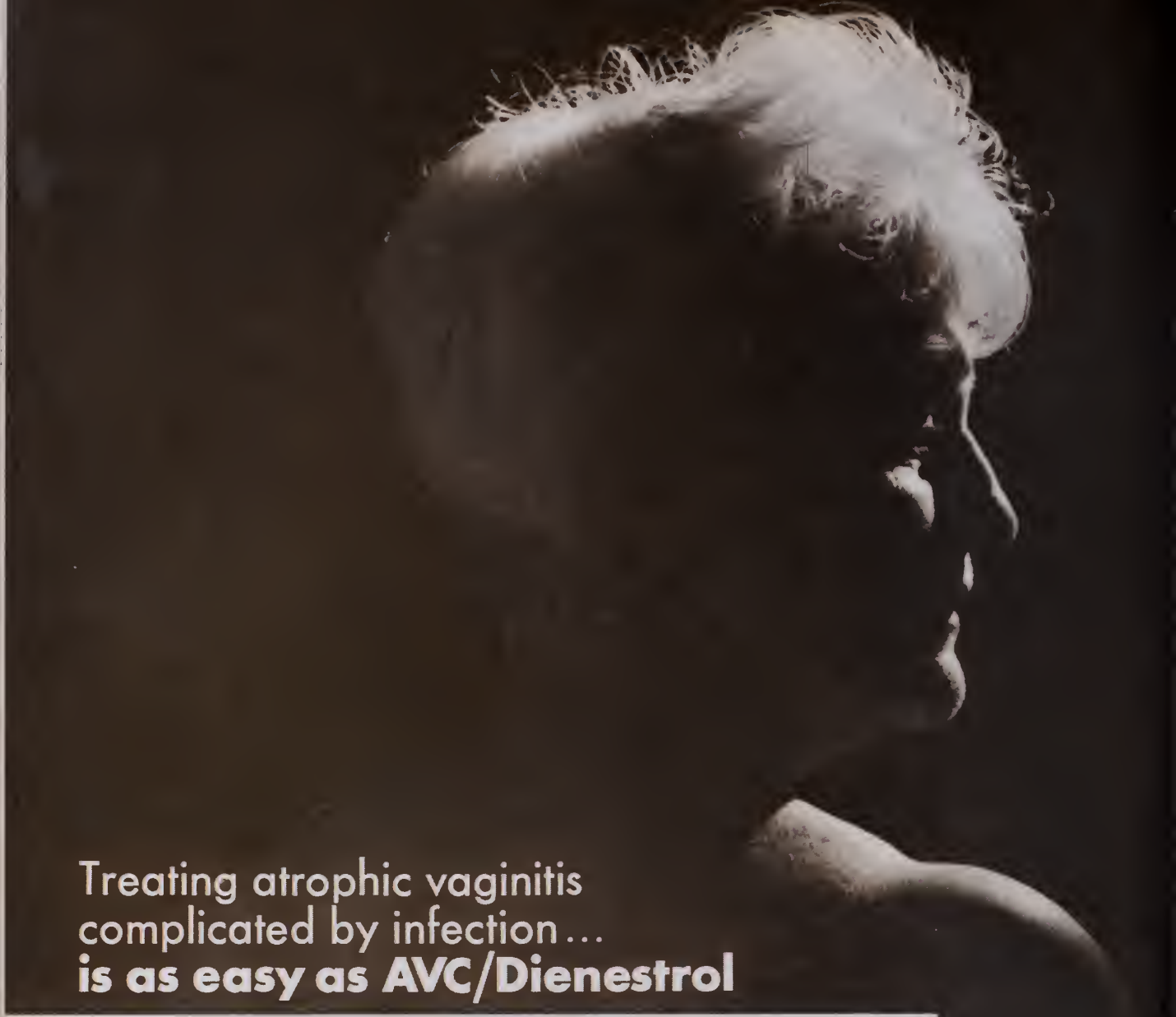
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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References: (1) Solerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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IN THE BOOKS

URINARY TRACT INFECTION IN CHILDHOOD AND ITS RELEVANCE TO DISEASE IN ADULT LIFE: by Victoria Smallpeice, M.A., M.D., F.R.C.P.; Published by the C. V. Mosby Company, St. Louis, 1969; 171 Pages; Price $9.50.

This monograph combines a rather detailed review of the literature with an analysis of a previously published series of 343 cases of urinary tract infection in children observed by the author over 17 years. While this is an excellent review of the etiology, diagnosis and treatment of urinary tract infection in children, it is disappointing to find that conclusions pertaining to the title of the book are drawn from the literature rather than from the author's personal series. Such a large series as this undoubtedly will be of great value after the cases have been followed longer, so that the true relevance of urinary tract infection in childhood to disease in adult life can be determined.

The chapter concerning the etiology of urinary tract infection in childhood is an excellent review. The literature is thoroughly scanned and the author's series is analyzed in regard to the incidence of duplicated ureters, vesicoureteral reflux and sex incidence in relation both to duplicated ureters and to infection. The discussion of evidence supporting the theory of perineal contamination leading to retrograde urethal infection in girls is extensive. The roles of obstruction, calculi, host defense, and the infecting organism are considered.

The chapters on diagnosis contain a rather lengthy review of methods of collection and examination of urine and a detailed review of the significance of the bacterial count.

The section concerning treatment discusses mainly the controversy between short and long term drug therapy of urinary tract infections. Surgical treatment is mentioned only briefly.

This book would appear to be an extremely valuable introductory source for those interested in learning the basic problems of urinary tract infections in childhood. It also is an excellent source of bibliographical material for those wishing to review in detail any certain aspect of this problem. It has little to offer for those already thoroughly familiar with the problems of urniary tract infections in childhood.

ARNOLD M. BELKER, M.D.

DIAGNOSIS AND MANAGEMENT OF PAIN SYNDROME: by Bernard E. Finneson; Published by the W. B. Saunders Company, Philadelphia; 337 Pages; Price $12.50.

Pain is second only to bleeding as the most common complaint bringing patients to physicians. Relief of pain is one goal to which physicians pledge themselves, and may be the only service they can offer to some patients. Understanding pain, its mechanism and pathways, the interrelationship of physician and patient with pain problems, often baffle and irritate both physician and patient.

Dr. Finneson's book is offered as a "guide to management of the pain problems commonly encountered", and presents concise information to explain pain mechanisms and pathways; explores the possible relationships of physicians and patients in pain, and presents some means of providing pain relief. Dr. Finneson, in his preface, disclaims completeness, "limiting the discussion to those techniques that have worked best for me". This disclaimer forestalls argument in controversial areas, of which there are but a few.

The material is organized in easily used fashion with a satisfactory index. The text is easily read with very few inaccuracies. Line drawings in abundance add lucidity to the text. A bibliography is glaringly absent.

The book itself is well designed and manufactured. It is of comfortable and convenient size. The type is easily read and printed on good paper.

The book should serve its purpose well in helping many physicians and patients understand pain problems and finding relief for those problems.

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Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

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THE INSURANCE PAGE



Be Not The First By Whom The New Are Tried, Nor Yet The Last To Lay The Old Aside

THE admonition of Alexander Pope, which appeared in "Essay on Criticism" is apparently good advice for physicians today. One wonders at times, however, if there are not some who are the last to lay the old aside. We are living in a period of great change, yet some seem to hold on to the memory of the horse and buggy doctor, yet none of us still make home calls in a buggy.

Those of you who have failed to sign the participating Physicians Agreement for Usual and Customary Programs with Blue Shield should again review their agreement and sign as a participating physician.

There seems to be some reluctance on the part of physicians in many of the County Societies to agree on peer review. It is the opinion of this writer that peer review will become a very important part of medical practice in the near future. The sooner each of us accepts this principle and documents the records of all patients, the better our medical practice will become.

There seem to be ideas in some circles that the individual medical practitioner need only express a medical opinion, and that he is not required to show how he arrived at this opinion.

The opinion of an expert witness is no longer acceptable in most of the courts when it is purely a statement of opinion. Courts now require an expert witness to show the facts to the court and explain how he arrived at his expert opinion. This does not seem to be an unreasonable demand, for it is by demonstrating one's skill at obtaining the facts and the logic by which he arrives at an expert opinion that one maintains his reputation as an expert.

If one documents all of his findings and demonstrates that he arrived at logical conclusions and that reasonable action was taken in treatments, there will be practically no work for the peer review committee. It is only when third parties are unable to understand an individual's claim, that the peer review mechanism is necessary.

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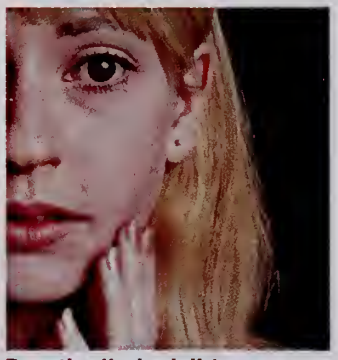


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Description: A transparent, inconspicuous, plastic surgical tape, impervious to moisture, slightly elastic and highly flexible. The corticosteroid flurandrenolone is uniformly distributed, 4 mcg./sq. cm., in the adhesive layer.

The adhesive is a synthetic copolymer of acrylate ester and acrylic acid, free from substances of plant origin. A paper liner permits handling and trimming before application.

Action: Cordran® (flurandrenolone, Lilly) has anti-inflammatory, antipruritic, and vasoconstrictive actions. The tape serves as both a vehicle and an occlusive dressing.

Indications: For adjunctive therapy of chronic recalcitrant dermatoses responsive to topical corticosteroids, particularly dry, scalling localized lesions. These include atopic dermatitis, contact dermatitis, eczema of hands and feet, lichen planus, lichen simplex chronicus, neurodermatitis, nummular eczema, psoriasis, seborrheic dermatitis, and stasis dermatitis.

Cordran Tape should be used only when its special features outweigh a possibly higher incidence of adverse reactions.

Cordran is recommended as a supplement to other preparations in the management of skin lesions. It may be used for symptomatic relief until contributing factors are corrected. In contact or allergic dermatitis, remove the offending contactant or allergen. Take a careful history, including a study of environmental contacts and use of drugs.

Contraindications: Chickenpox, vaccinia; patients with a history of hypersensitivity to any of its components. Not recommended for lesions exuding serum or in intertriginous areas.

Warning: ***Usage in Pregnancy***—Although adverse effects on pregnancy have not been reported, safety of the use of topical corticosteroids on pregnant women has not been absolutely established. Do not use extensively on pregnant patients in large amounts or for prolonged periods.

Precautions: If irritation develops, discontinue the product and institute appropriate therapy.

In the presence of infection, use appropriate antifungal or antibacterial agents. If a prompt response does not occur, discontinue the corticosteroid until the infection is adequately controlled.

If extensive areas are treated, take suitable precautions against the possibility of increased systemic absorption. Exercise particular care with infants and young children.

Adverse Reactions: The following local adverse reactions have been reported with topical corticosteroids, with or without occlusive dressings: burning sensations, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation.

The following may occur more frequently with occlusive dressings than without: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria. In addition, the tape may cause purpura and stripping of the epidermis.

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In most cases, the tape should be replaced after twelve hours. Wash the skin and allow it to dry for an hour before reapplying the tape. When necessary, the tape may be used only at nighttime. Loose ends or corners may be trimmed off and replaced with fresh tape.

Directions for the patient are included in each package.

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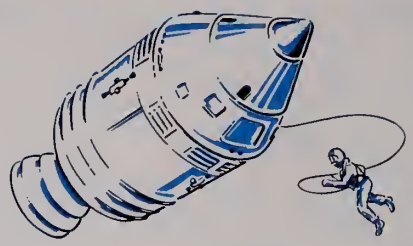
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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19 PANMED television series, "Newer Psychotherapeutic Agents: The Antidepressants," in Louisville, WKPC-TV 10 p.m.

21 PANMED television series, "Dialogue With Life," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

26 PANMED television series, "Dialogue With Life," in Louisville, WKPC-TV 10 p.m.

28 PANMED television series, "Gastric Ulcer — Benign or Malignant," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

29-31 Symposium on Modern Methods for the Medical Work-Up, University of Kentucky Medical Center, Lexington

FEBRUARY

2 PANMED television series, "Gastric Ulcer — Benign or Malignant," in Louisville, WKPC-TV 10 p.m.

4 PANMED television series, "Four-handed Dentistry," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

4 Postgraduate course, "Current Concepts in Gastrointestinal and Biliary Tract Surgery," University of Kentucky Medical Center, Lexington.

7 Symposium on "Treatment of Oropharyngeal Cancer," sponsored by the University of Louisville School of Medicine and Dentistry, 8:30 a.m. - 3:00 p.m., Rankin Amphitheater, General Hospital, Louisville

9 PANMED television series, "Four-handed Dentistry," in Louisville, WKPC-TV 10 p.m.

11 PANMED television series, "Family Prescription Records," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

16 PANMED television series, "Family Prescription Records," in Louisville, WKPC-TV 10 p.m.

MARCH

18-20 Postgraduate course, "The Head of the Child," University of Kentucky Medical Center, Lexington.

25-26 "Symposium on Cardiovascular Disease," sponsored by the Heart Association of Louisville and Jefferson County, Stouffer's Louisville Inn

APRIL

2 Fifteenth Annual Spring Clinical Conference, Lexington Clinic, "Diabetes Mellitus-1970," Lexington

8-9 KMA INTERIM MEETING, "Kentucky Medicine in the 70's," Kentucky Dam Village State Park, Gilbertsville

IN SURROUNDING STATES

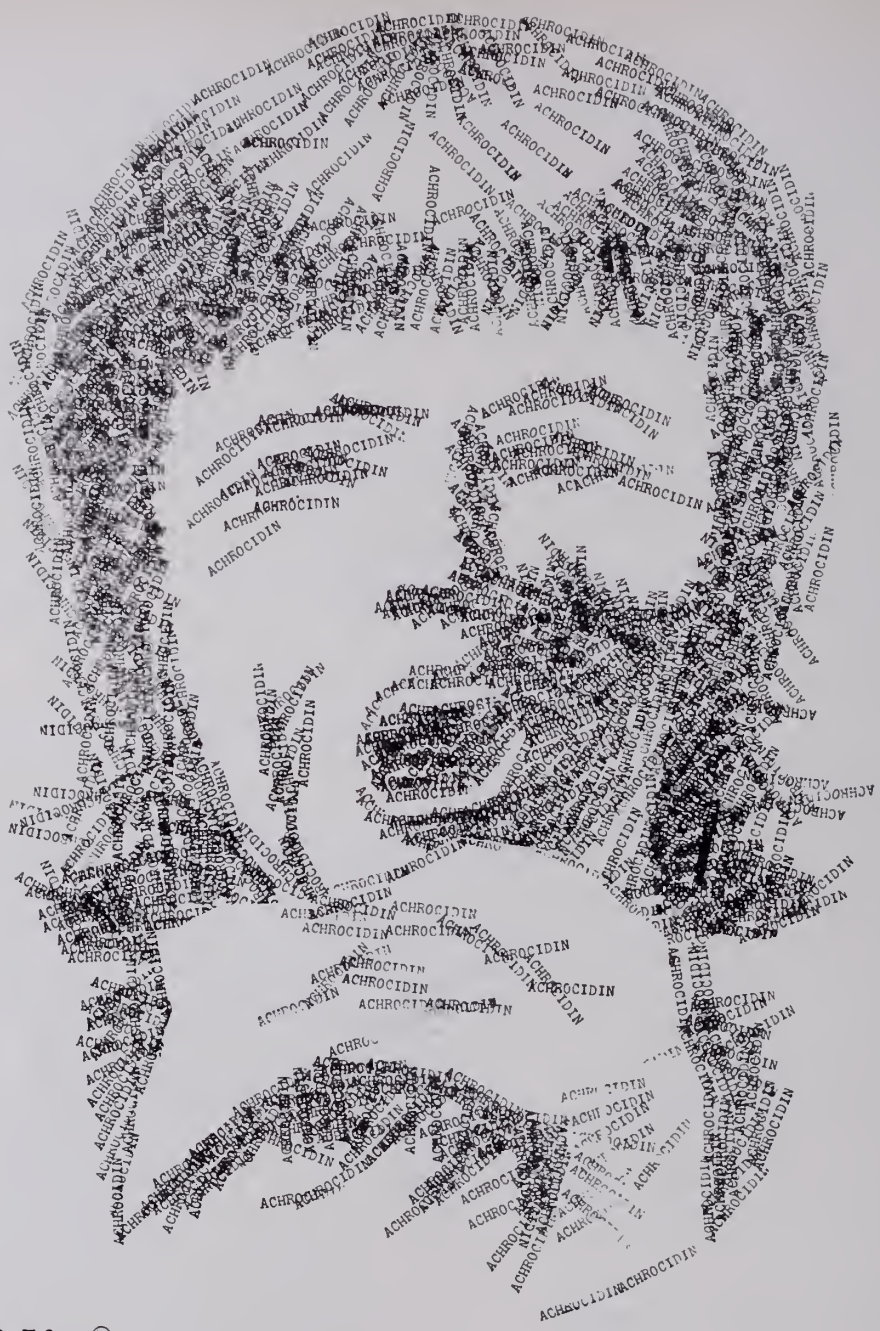
JANUARY

2-6 Postgraduate course, "Function and Dysfunction of Gastrointestinal Tract," American College of Physicians, Bal Harbour, Florida

14-15 Postgraduate course, "Selected Problems in General Surgery and Vascular Surgery," Cleveland Clinic Educational Foundation, Cleveland

20-21 Seminar on Clinical Psychiatry, The Medical College of Georgia, Augusta

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Contraindications: Hypersensitivity to any component.

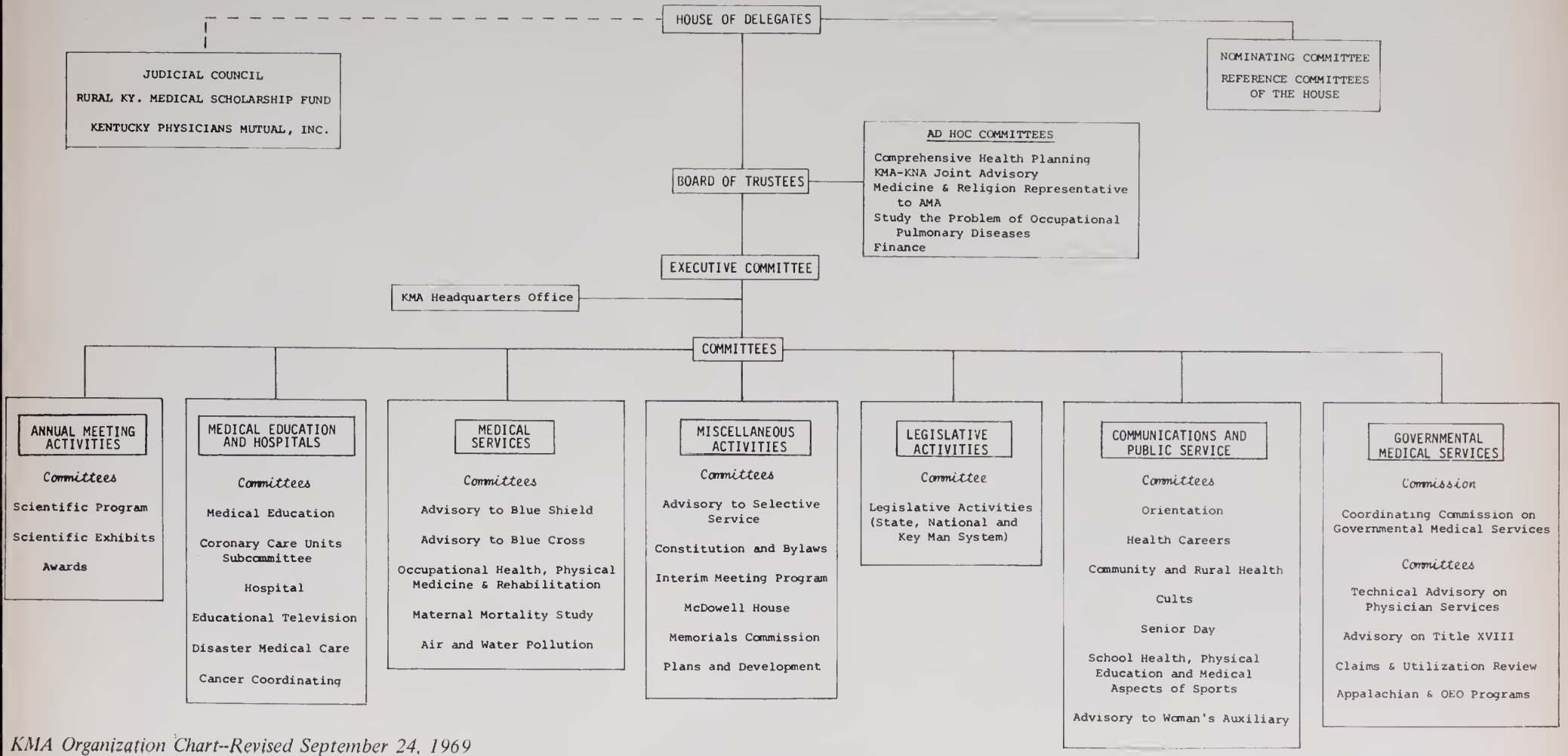
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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The JOURNAL of the
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VOLUME 68 JANUARY 1970 No. 1

Can This Be Histoplasmosis.....?

N. A. SALIBA, M.D.*

Louisville, Kentucky

An outline of the acute pulmonary, chronic pulmonary and disseminated types of histoplasmosis is given. The importance of a high degree of suspicion, and screening with skin testing and complement fixation studies is emphasized. Treatment with Amphotericin-B is discussed, and examples of the various forms of histoplasmosis are presented.

THERE IS little doubt that practicing physicians in endemic areas often need to ask themselves the question "Can this be histoplasmosis?". It has already been shown that many "histoplasmosis" patients who are hospitalized, have an incorrect diagnosis because of an insufficient degree of suspicion, or the lack of appropriate laboratory evaluation[1, 2].

Kentucky is well within the geographic endemic area for histoplasmosis in the United States, that is the Ohio-Mississippi Valley Region. However, this fungus is by no means limited to the continental United States, as it has been isolated in over 30 countries, either from patients or soil samples. The literature includes reports from Europe, North and South America, Africa, Asia and Australia. By far the largest number of cases has been reported from the United States.

Histoplasmin skin sensitivity can be used to determine the prevalence of infection with Histoplasma capsulatum in a community. This sensitivity in Kentucky ranges from a low of approximately 22 per cent in the eastern part of the state, to a high of 95 per cent in the central part of Kentucky. The area around Jefferson County has an estimated 68 per cent histoplasmin sensitivity. A certain degree of clinical suspicion of histoplasmosis, followed by screening examinations with histoplasmin skin testing and complement fixation studies, can certainly prove rewarding[1, 3]. Many patients with chronic pulmonary disease and a positive complement fixation for histoplasmosis can be proved to have viable organisms of Histoplasma capulatum in their sputum. Proof often requires a series of at least six sputum cultures carried out in an adequately equipped laboratory. On the other hand, as Sweany points out, the complement fixation may almost completely disappear in fulminating cases[4]. While a positive complement fixation test usually indicates active disease, occasional patients do not develop these antibodies (about 10—15 per cent of the total). Thus, in any chronic unresolving pneumonia or pyrexia of unexplained origin, cultures as well as serologic studies are indicated.

Material and Method

District Two State Tuberculosis Hospital (Hazelwood) has participated in a U. S. Public Health Service Mycoses Therapy Study since 1958. This is the largest cooperative study of its type, and this group has collected a series of 1,288 mycologically proved cases, approximately 920 of these being proved

*Director, District Two State Tuberculosis Hospital, Louisville

histoplasmosis of various types, mostly chronic cavitary pulmonary.

The three hospitals in this study contributing the largest number of cases are one in Missouri, one in Arkansas and this one in Louisville. We have contributed (a) a series of 129 cases of histoplasmosis confirmed by sputum culture and/or tissue examination; (b) a second group of 36 cases that have been classified highly suspicious for histoplasmosis, but the fungus was not identified by culture or microscopy. In these patients tuberculosis or other significant pathology was not established, the complement fixation test was positive for histoplasmosis, and one usually found a persistence or exacerbation of symptoms or else a deterioration of pulmonary changes by x-ray during follow-up.



FIG. 1. 2-year-old girl admitted 4/17/68 with a respiratory illness associated with a right middle lobe pneumonia. Histoplasmin skin test was 12 mm. induration, and PPD negative. Her complement fixation was positive for Histoplasmosis H 1 - 1:64, H 2 - 1:256, Blasto 1:16. The sputum submitted was negative, but other members of the family had also been infected with Histoplasmosis. H. capsulatum was isolated from soil samples around her residence. This child improved clinically and radiologically without specific therapy, and remains well under close O.P. supervision.

Of the mycologically proved cases, 78 were treated with intravenous Amphotericin-B in a dosage ranging from 470 mg. to 2895 mg. total dosage for a single course; in some cases these courses were repeated when relapse occurred. In our series the largest total dosage of Amphotericin-B over a number of courses given to an individual patient was 6520 mg. A smaller number of patients in the suspect group were also treated with Amphotericin-B because of the above noted clinical findings, and this often resulted in clinical and radiologic improvement. Twenty-five patients have received resectional surgery[5].



FIG. 2. 24-year-old W.M. admitted 5/4/66 acutely ill and with evidence of miliary disease. His complement fixation was positive for Histoplasmosis H 1 - 1:128, H 2 - 1:8. His bone marrow and sputum cultures were positive for H. capsulatum. He made a remarkable recovery after 2210 mg. Amphotericin-B; subsequently he suffered relapses which necessitated further treatment. He is now well and working.

Most of these cases have been originally

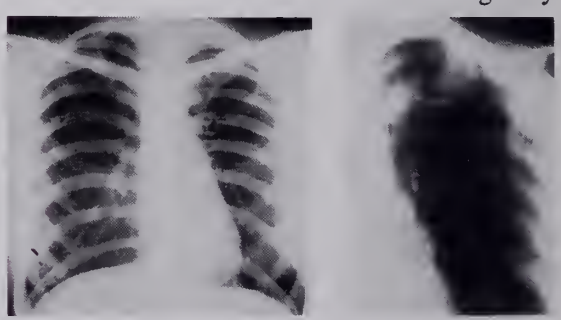


FIG. 3. 17-year-old W.F. student. Complement fixation was positive for Histoplasmosis H 1 - 1:32, H 2 - 1:64. Chest x-ray showed left apical cavitary disease. A left upper lobectomy was carried out on 4/20/65 under cover of Amphotericin-B (1265 mg. total course). Tissue was positive for H. capsulatum on microscopy and culture. When seen last December, 1968, she was doing well, with no evidence of active disease.

suspected from screening by the serologic test which is the best index of active disease. Routine admissions at the six District Tuberculosis Hospitals in Kentucky are screened by such tests. The percentages of positive serologic tests found in each hospital district are as follows for a recent survey carried our between 1967-1968: Madisonville, Ashland and London Hospital District had 12 to 16 per cent positive tests for histoplasmosis; whereas Louisville, Paris and Glasgow Hospital District had 26 to 33 per cent.



FIG. 4. This is a routine x-ray showing a large stippled calcific lesion in R. paratracheal region. Histoplasmin skin test was positive, PPD negative. C.F. was positive for Histoplasmosis H 1 - 1:64, H 2 - 1:32. This man was symptom free.

Clinical Types of Histoplasmosis

Because of our experience during the past 12 years or so, it has become evident that the possibility of histoplasmosis needs to be considered in practically all cases of chronic pulmonary disease, in many cases of acute pulmonary disease, and in a substantial number of patients with generalized systemic disease. The various clinical types encountered are as follows:

1. Acute pulmonary.

a. Primary infection: This is an influenza-like illness and may at times resemble primary tuberculous infection or even sarcoidosis. Hilar glands may be enlarged, or one may find scattered pulmonary foci on chest x-ray examination. Erythema nodosum has also been described somewhat infrequently.

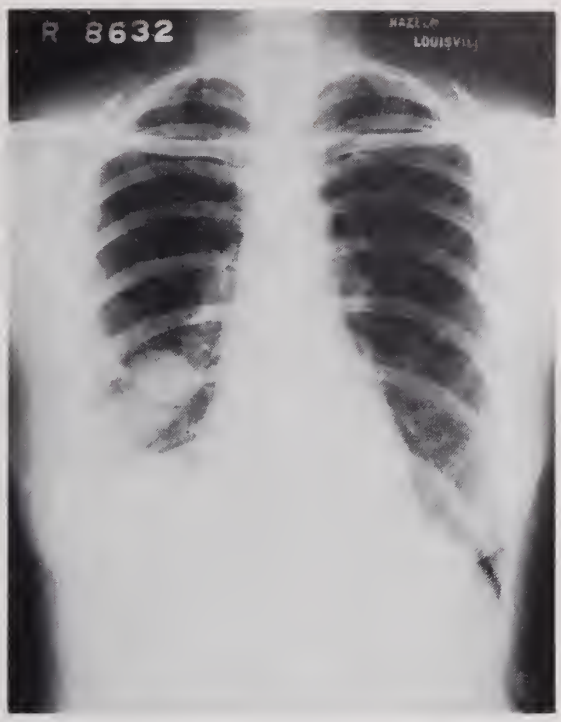


FIG. 5. 46-year-old W.F. admitted 8/29/60 with a mass in her R. lung. Her PPD was negative and Histoplasmin skin test positive. Complement fixation was negative for Histoplasmosis H 1, and 1:8 for H 2. Resection of basal segments R. lower lobe was carried out on 9/1/60 under cover of Amphotericin-B, 1544 mg. Tissue was positive for H. capsulatum.

b. Pneumonitis: This will present as a more severe variety of the acute primary infection, a more severe respiratory illness with pneumonic areas on chest x-ray. A specific diagnosis may be extremely difficult without a high degree of suspicion of histoplasmosis followed by appropriate laboratory studies. It can be confused with bacterial or viral pneumonia, so that, any pneumonitis persisting for more than a few days, or resistant to ordinary antibiotics, should be suspected (Fig. 1).

c. Disseminated (Miliary): These patients are usually critically ill and the presenting clinical picture may be indistinguishable from miliary tuberculosis. They represent patients whose resistance does not confine the fungal infection to the lungs, but it becomes disseminated by

the blood stream (Fig. 2). The clinical picture is characterized by fever and hepatosplenomegaly. Without treatment this type of histoplasmosis infection may be rapidly progressive and fatal[6]; on the other hand prompt treatment can produce a dramatic response. The adrenal glands may also be involved in a substantial number of cases, Rubin et al reporting a 20 per cent incidence in their series[7].

2. Chronic pulmonary.

a. Cavitary: This is the most frequent type of chronic pulmonary histoplasmosis encountered. The pulmonary disease can be very extensive, the cavitation may be single or multiple, unilateral or bilateral. Without diagnosis and specific treatment, this condition is slowly progressive in the majority of cases; over a period of years there is exacerbation and remission, increased destruction of pulmonary parenchyma with increased disability, and eventually death in many cases. Characteristically, this form is indistinguishable from pulmonary tuberculosis and may be indistinguishable from fungal or other chronic pulmonary diseases (Fig. 3).

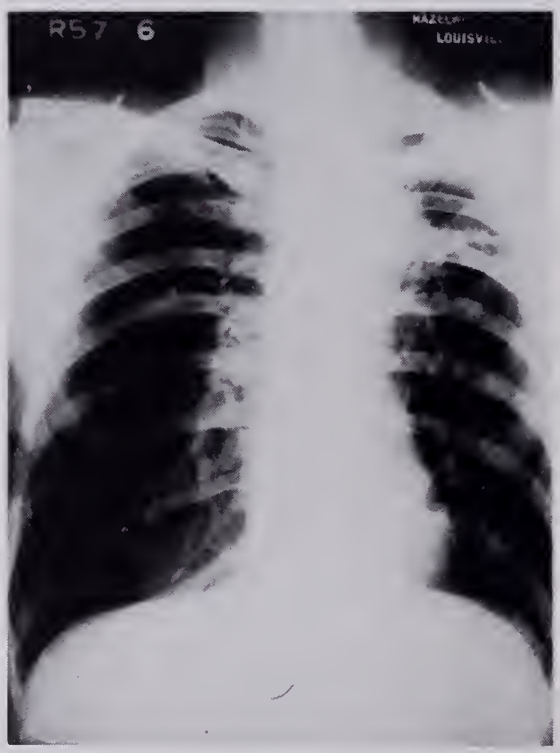


FIG. 6. 48-year-old W.M. admitted 10/29/57 with a large cavity in the LUL, some infiltration in the L. mid-lung field and a minimal spread to the R. upper lobe. Sputum cultures were positive for tuberculosis and histoplasmosis. Patient received antituberculosis and antifungal treatment, with clinical improvement and sputum conversion. He declined resectional surgery. He suffered relapses from his Histoplasmosis and died in 1963 from superior vena cava obstruction.



FIG. 7. 60-year-old W.M. admitted 6/13/62 with extensive bilateral fibrocavitary disease and positive sputum smears and cultures for tuberculosis. He was responding fairly well and his sputum converted in September, 1962; but vague abdominal complaints persisted and he was not too cooperative with pursuing the clinical evaluation. He was transferred to another hospital April, 1963, for furher study. He died there, and at necropsy disseminated granulomatous disease was found in the lungs, adrenals, kidneys, spleen, liver. Tissues were positive for H. capsulatum. The tuberculosis status was apparently quiescent.

b. Calcification: This type may present with calcifications in various organs, and in the lung fields either as scattered pulmonary calcification or more frequently mulberry type calcification in the hilar and mediastinal region. These can attain significant size and may occasionally result in complications such as compression of the trachea or esophagus, or superior vena cava obstruction (Fig. 4).

c. Histoplasmoma: This presents as a coin lesion on chest x-ray and sometimes as a larger density which could perhaps represent an inspissated cavity or a caseo-necrotic granuloma. The differential diagnosis would include the possibility

of a carcinoma or a benign tumor, or else other types of granulomas (Fig. 5).

3. Associated diseases.

In this type two or more fungi may co-exist, for example, histoplasmosis associated with blastomycosis or aspergillosis. Histoplasmosis has also been found in the presence of carcinoma, leukemia, etc. Not infrequently it is associated with tuberculosis and in a certain percentage of patients these two chronic diseases may be encountered simultaneously in an active form[8, 9]. In certain patients one of the diseases may precede or follow the other by a period of many months or even a few years (Fig. 6, 7). On the other hand there have been cited examples of shedding of histoplasmosis organisms in the process of a progressive form of tuberculosis; or the shedding of occasional mycobacteria in the process of an active histoplasmosis infection[9]. In this case the active progressive disease is the actual pathologic process, whereas the shedded organisms may simply represent a previous infection rather than a concurrent disease process.

Discussion

Of the three principal types of histoplasmosis (a) acute pulmonary, (b) chronic pulmonary, (c) disseminated, the acute pulmonary form is probably the most frequently unrecognized. But other types of histoplasmosis can also be misdiagnosed because they can be mistaken for tuberculosis, carcinoma, sarcoidosis, etc.

Most of the acute forms are usually encountered in the private practice of medicine or in general type hospitals. The chronic pulmonary form on the other hand is often found in tuberculosis or other chronic disease hospitals, either as suspect tuberculosis or for diagnostic purposes. The disseminated form is less common, but may be encountered in any situation.

Besides the already recognized source of infection by Histoplasma capsulatum in rural areas, Furcolow et al[10] points out the possible sources of infection among city dwellers. Here, one needs to consider visits to farms or prior rural residence, exposure in urban structures contaminated by bird droppings, importation of contaminated farm soil or manure as a fertilizer, and exposure in wooded

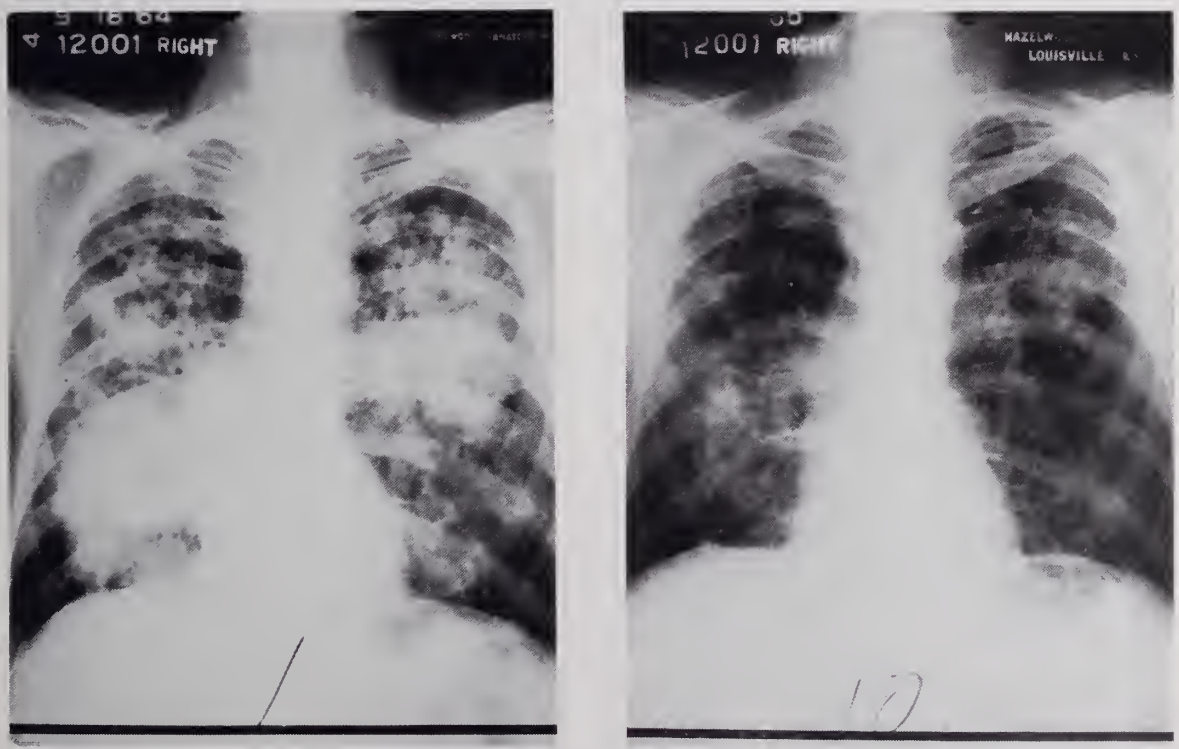


FIG. 8. 59-year-old W.M. first seen 9/18/64 acutely ill, with extensive infiltrative and fibrocavitary disease on chest x-ray (A). C.F. was positive for Histoplasmosis H 1 - 1:256, H 2 - 1:256. Sputum cultures were positive for H. capsulatum. Chest x-ray (B) shows marked improvement in the disease process after 2925 mg. Amphotericin-B, this concided with his clinical improvement.

or open park areas contaminated by bird droppings. Small localized epidemics have been recorded following such exposure.

The acute pulmonary form of histoplasmosis is usually benign and self-limiting and does not necessarily require specific treatment. In the chronic pulmonary form, some spontaneous improvement may be noted, but there is accumulated evidence to show that untreated patients fare poorly in comparison with treated patients (Fig. 8 A, B) as regards progression of disease with disability and mortality. The disseminated variety carries the worst prognosis and therefore early diagnosis and specific treatment become mandatory[11, 12].

Even in experienced hands, treatment currently available is not simple and requires careful supervision. It consists of intravenous Amphotericin-B usually given three times per week, or daily in critical cases, and resectional surgery for localized major disease. Amphotericin-B has proved itself a wide spectrum antifungal agent for a variety of these diseases and many patients have benefitted from its use. The most serious toxic effect is potential nephrotoxicity which is dose related[13]. The need for treatment is recognized in at least two types of histoplasmosis, and further study will yield valuable data as to the optimum dose to achieve maximum clinical effect, at the same time maintaining a low spectrum of toxicity. It is also hoped that in the not too distant future other agents will become available that are even more effective and easier to administer.

Acknowledgement

I am indebted to Dr. M. L. Furcolow, Department of Community Medicine, University of Kentucky, for his review and suggestions.

Bibliography

1. Furcolow, M. L., "Histoplasmosis", *GP,* 18, 117, 1958.
2. Saliba, N. A., "The Systemic Mycoses in Differential Diagnosis of Chronic Pulmonary Disease", *Dis. Chest,* 53, 73. 1968.
3. Saliba, A., and Beatty, O. A., "Pulmonary Histoplasmosis", *JAMA,* 173, 902, 1960.
4. Sweany, H. O., Gorelick, D., Coller, F. C., and Jones, J. L., "Pathogenic Findings in Benign Pulmonary Histoplasmosis", *Dis. Chest,* 34, 1, 1958.
5. Levene, N., Slesh, M. Z., Torres, J., and Saliba, N. A., "Surgical Aspects of Progressive Cavitary Pulmonary Histoplasmosis", *Ann. Thorac. Surg.,* 5, 23, 1968.
6. Saliba, N. A., and Anderson, W. H., "Acute Disseminated Histoplasmosis", *Am. Rev. Resp. Dis.,* 95, 94, 1967.
7. Rubin, H., Furcolow, M. L., Yates, J. L and Brasher, C. A., "The Course and Prognosis of Histoplasmosis", *Am. J. Medicine,* 27, 278, 1959.
8. Beatty, O. A., and Saliba, A., "Co-existing Pulmonary Fungus Infection and Tuberculosis at District Two State Hospital", *J. of Ky. Med. Assn.,* 61, 502, 1967.
9. Goodwin, R. A., Snell, J. D., Hubbard, W. W., and Terry, R. T., "Relationships in Combined Pulmonary Infection with Histoplasma Capsulatum and Mycobacterium Tuberculosis", *Am. Rev. Resp. Dis.,* 96, 990, 1967.
10. Furcolow, M. L., Tosh, F. E., Larsh, H. W., Lynch, J. H., and Shaw, J., "The Emerging Pattern of Urban Histoplasmosis", *N. Eng. J. Med.,* 264, 1226, 1961.
11. U.S.P.H.S. Cooperative Mycoses Study, "Course and Prognosis of Untreated Histoplasmosis", *JAMA,* 177, 292, 1961.
12. Campbell, G. D., Einstein, H. E., Dravetz, H. M. and Utz, J. P. "Indications for Chemotheraphy in the Pulmonary Myocses", *Dis. Chest,* 55, 160, 1969.
13. Utz, J., Bennett, J. E., Brandriss, M. W., Butler, W. T., and Hill, G. J., "Amphotericin-B Toxicity", *Ann. Int. Med.,* 61, 334, 1964.

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A Radiologic Clue to Intestinal Infarction--Portal Venous Gas

Jan S. Hirschfield, M.D., Jerome P. Lacy and R. Joe Sayers*

Louisville, Kentucky

Recognition of radiographic portal venous gas and/or pneumatosis intestinalis may lead to an earlier diagnosis of intestinal infarction with a chance for survival.

PERCENTAGE survival from intestinal infarction is low since the complications of intestinal necrosis usually progress so rapidly that therapy is inadequate. Recently, a number of reports in the radiologic literature have stressed the importance of portal venous gas seen on abdominal radiographs in association with intestinal infarction[1-6]. However, reports in the internal medicine literature have been few[7, 8]. This communication intends to reacquaint the physician with a radiologic sign associated with intestinal necrosis in hopes of an early diagnosis.

Case Report

B. B. C. (LGH No. 204-699) was a 79-year-old Negro female admitted to the Louisville General Hospital August 9, 1968, because of nausea and abdominal pain of 24 hours duration. Four days prior to admission, while taking digitalis, the patient was treated with an intramuscular mercurial diuretic because of ankle edema and shortness of breath.

On the day of admission she developed severe abdominal cramping pain with nausea but no vomiting. She reported no hematemesis, jaundice, diarrhea, melena or bloody stools. In 1950 a diagnosis of arteriosclerotic heart disease was made and since then she has been hospitalized on several occasions for episodes of congestive heart failure. She was treated for pneumonia and digitalis intoxication in February, 1968. A cholecystectomy was performed in 1960.

Physical examination: B.P. 120/70; pulse 120/min. and irregular; temperature 97°F.; respiration 19/min. She was cachectic and pertinent findings included a soft abdomen without tenderness or distension, a liver palpable 4 cm. below the right costal margin and active bowel sounds. The chest was clear to ausculation and percussion. No cardiac murmurs were heard but an apical to radial pulse deficit was detected. Pedal edema was absent. Laboratory data showed a hemoglobin of 16 gm per cent, hematocrit 49 per cent, white blood cell count 7,750/mm^3 with 74 per cent neutrophils, blood urea nitrogen 58 mg per cent, sodium 134 mEq/L, potassium 3.8 mEq/L, chloride 90 mEq/L and bicarbonate 31 mEq/L. Atrial fibrillation and ST changes compatible with digitalis effect were seen on the electrocardiogram.

The digitalis was discontinued and the patient's arrhythmia was treated with intravenous diphenylhydantoin. A supine abdominal roentgenogram was interpreted as normal. The abdominal pain decreased in intensity but recurred 48 hours after admission. Physical findings revealed a diffusely tender, slightly distended abdomen with audible bowel sounds. She then vomited a yellowish fluid and passed several bloody stools. The hematocrit was 29 per cent and an electrocardiogram showed a regular sinus rhythm with a left bundle branch block. A supine roentgenogram of the abdomen suggested adynamic ileus and gas in the portal venous circulation (Fig. 1). An abdominal paracentesis revealed bloody fluid. The patient was given intravenous kanamycin, and penicillin and sodium colistimethate but expired four hours later.

At postmortem examination, the abdominal cavity revealed 500 ml. of bloody, foul smelling fluid. The gallbladder was absent and multiple adhesions were present on the inferior surface of the liver. The alimentary

From the division of gastroenterology, department of medicine, University of Louisville School of Medicine, Louisville



FIG. 1. Supine abdominal radiograph with gas in the portal venous system over the hepatic area (upper horizontal arrow) and a linear air density (lower vertical arrow) which may be consistent with intestinal intramural air.

canal from the stomach to the rectum contained bloody, foul smelling unformed feces. No perforation of the stomach, small or large intestine was found. The bowel was friable to manual manipulation. The last 10 cm. of the duodenum and the first 20 cm. of the jejunum had numerous submucosal cysts measuring up to 0.5 cm. in size. Several of the cysts were incised and found to contain gas. The mesenteric arteries and the portal venous system were free of thrombosis.

Other findings included bilateral hydrothorax, an enlarged heart with diffuse fibrosis and arteriosclerosis of the pulmonary, aortic, renal, cartoid and cerebral arteries.

Microscopically the stomach showed ischemic degeneration while the small intestine was frankly infarcted (Fig. 2A). Areas of submucosal cysts were present in the upper small intestine (Fig. 2B). The cysts had no epithelial lining or giant cells. Small anaerobic gram positive organisms and citrobacter group were cultured from the abdominal fluid. Other microscopic findings included pulmonary emphysema, anthracotic fibrosis and a focus of undifferentiated bronchogenic carcinoma of the left upper lobe.

Discussion

Gas in the portal venous system is a recent radiographic discovery[1]. Portal venous gas is distinguished radiographically from biliary tract gas by the presence of air density in the vessels to the periphery of the liver lobule. Sussman and Senturia state that the centripetal flow of bile prevents gas if present in the biliary tract, from reaching the small biliary radical and that portal venous flow is obviously centrifugal[2]. Therefore, gas if seen radiologically near the periphery of the liver lobule is more likely to be in the portal venous system than in the biliary tree.

Gas in the portal venous system is an ominous sign, since it is so often associated with intestinal necrosis and the ensuing death of the patient. In a recent review of 54 cases, four patients survived following the radiographic diagnosis[8]. The pathogenesis of gas in the portal venous tract is still not clear but bacteremia with gas-forming organisms and gas entry through a disrupted intestinal mucosa have been postulated[8]. Therefore, antibiotic therapy and/or surgical intervention may be instituted following discovery of the presence of portal venous gas. Unfortunately, previous experience tells us that this radiographic clue may be a late sign in the progression of the disease. Only future experience with knowledge of this sign will define the time relationship between diagnosis and possible recovery.

The findings of pneumatosis intestinalis at postmortem exam may be coincidental or related to distension of the bowel with air entrance into the submucosa and/or bacterial organisms gas production. In retrospect the

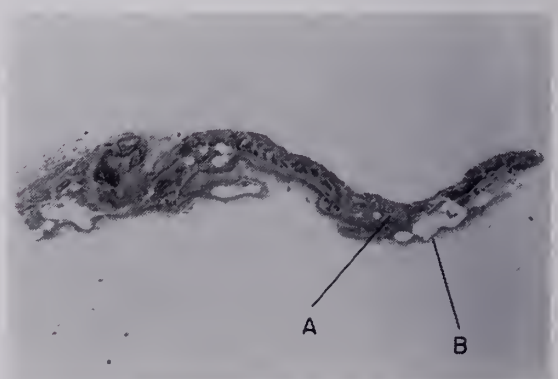


FIG. 2. A histological section of the small intestine (7X) at postmortem showing a loss of integrity of the submucosa and muscle secondary to infarction (A) and submucosal cysts (pneumatosis intestinalis) (B).

linear air line seen on abdominal x-ray (Fig. 1) may be related to the pneumatosis.

The presence of both radiographic portal venous gas and pneumatosis intestinalis may be diagnostic of intestinal death[8]. Rigler states that the term pneumatosis intestinalis refers to the benign cystic form and not the intramural gas seen with intestinal infarction, which is usually linear[5].

The cause of intestinal necrosis is not well understood. Severe congestive failure, shock, sepsis and digitalis intoxication with cardiac arrhythmias have been implicated[10-13]. The absence of vascular thrombosis seen at postmortem has been previously described in other cases of intestinal necrosis[7, 9].

An earlier diagnosis of intestinal infarction may be possible with clinical suspicion and close observation of frequent abdominal roentgenograms for portal venous gas and intramural air.

Summary

Radiographic portal venous gas was found antemortem in a 79-year-old woman who died of intestinal infarction. Intestinal intramural gas was found at postmortem examination, and possibly in retrospect in the abdominal radiograph. Recognition of these two radiologic entities may alert the physician to the diagnosis of intestinal necrosis so that therapy can be instituted with hopes of survival.

Bibliography

1. Wolfe, J. N., Evans, W. A.: Gas in the portal veins of liver in infants: Roentgenographic demonstration with postmortem anatomical correlation. *Amer. J. Roentgenol.* 74: 486, 1955.
2. Sussman, N., Senturia, H. R.: Gas embolization of portal venous system. *Amer. J. Roentgenol.* 83: 847, 1960.
3. Wiot, J. F., Felson, B.: Gas in portal venous system. *Amer. J. Roentgenol.* 86: 920, 1961.
4. Schorr, S.: Small-intestinal intramural air. *Radiology* 81: 285, 1963.
5. Rigler, L. G., Pogue, W. L.: Roentgen signs of intestinal necrosis. *Amer. J. Roentgenol.* 94: 402, 1965.
6. Paciulli, J., Jacobson, G.: Survival following roentgenographic demonstrations of gas in the hepatic portal venous system. *Amer. J. Roentgenol.* 99: 629, 1967.
7. Musa, B. U.: Intestinal infarction without mesenteric vascular occlusion. A report of 31 cases. *Ann. Int. Med.* 63:, 783, 1965.
8. Fred, H. L., Mayhall, C. G., Harle, T. S.: Hepatic portal venous gas. A review and report on six new cases. *Amer. J. Med.* 44: 557, 1968.
9. Bialostozky, D., Contreras, R., Tinajeros, C. A., Franco-Browder, S.: Gastrointestinal hemorrhagic necrosis: Report of ten cases. *Amer. J. Med.* 46: 90, 1969.
10. Deal, C. P., Jr., Green, H. D.: Comparison of changes in mesenteric resistance following splanchnic nerve stimulation with responses to epinephrine and norepinephrine. *Circulation Research.* 4: 38, 1956.
11. Corday, E., Williams, J. H.: Effect of shock and vasopressor drugs on the regional circulation of the brain, heart, liver and kidney. *Amer. J. Med.* 29: 228, 1960.
12. Gazes, P. C., Holmes, C. R., Moseley, V., Pratt-Thomas, H. R.: Acute hemorrhage and necrosis of the intestine associated with digitalization. *Circulation* 23: 358, 1961.
13. Byrne, J. J.: Shock. *New England J. Med.* 275: 543, 1966.

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Steroid Replacement Therapy†

Warren H. Pearse, M.D.*

The arguments for and against hormonal therapy in menopausal and post-menopausal women are presented. Two alternate methods of replacement therapy are presented.

MANY medical controversies generate more heat than light. Discussions of revision of our abortion laws have led to the proponents being accused of murder and the opponents of dooming women and children to a lifetime of suffering. Letters about sex education in the schools suggest that the opponents favor illegitimate pregnancy and ignorance while the proponents are communist inspired. Like most emotional arguments, such catch phrases indicate that the discussion has merit on both sides, that all the evidence is not in, and that the issue is not yet fully resolved.

To some extent it has been this way with steroid replacement therapy, which we are defining as long-term replacement of one or more steroid hormones in the menopausal and post-menopausal female. The proponents have cried "feminine forever" which at least in today's society is a cry likely to be attractive to most women. The opponents have generally waved a flag bearing the word cancer which is likely to be quite an unattractive proposition.

My objectives are to state briefly the nature of the problem, outline some of the arguments for and against the use of long term replacement therapy, and finally to indicate two alternate regimens out of many possible approaches, which to me seem reasonable.

There are around 100 million women in this country, and I suppose for that all of us can be thankful. About 30 million of them are under age 15. About 40 million are between ages 15 and 44. It is worthwhile to note that of these 40 million, 20 million are at risk of pregnancy by being married and not surgically or otherwise infertile. Of this 20 million, about one-third, or around 7 million, are now on oral contraceptives. Many of these individuals will be approaching menopause with a long experience in constant hormone medication.

There are 30 million women aged 45 and older in this country who are potential candidates for steroid replacement therapy during and after the menopause. We should note that contrary to the expectation of our medical students that menopause usually occurs at about age 45, and contrary to the expectations of most women who relate every symptom from age 35 on to the "change of life," the average last menstrual period among women in this country is almost at age 51.

What are the arguments of those who favor long term steroid replacement therapy? First, 85 per cent of menopausal women have some symptoms from the menopause and 60 per cent of them will benefit from estrogen therapy. Second, estrogen therapy prevents atherosclerosis. Evidence such as the facts that bilateral oophorectomy makes atherosclerosis more severe, that castration before the natural menopause results in an increased frequency of coronary artery disease, and that estrogen reduces serum lipids and serum cholesterol levels have been adduced. Thirdly, estrogens are stated to prevent osteoporosis. Evidence is cited that estrogens induce positive calcium and phosphorus balance, that they inhibit resorption of bone, that they reduce pain and prevent further fractures, as well as preventing further loss of height in osteoporosis. Fourthly, estrogens do prevent genital atrophy especially in the area of the vagina and vulva, and this is easily demonstrated clinically. Finally, there is no direct evidence that long term estrogen therapy increases the incidence of breast cancer or endometrial carcinoma.

Those opposing estrogen therapy turn to these same arguments but with a different

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†Presented at the second General Session, 1969 KMA Annual Meeting, September 24, Louisville

**Professor and chairman, department of obstetrics and gynecology, University of Nebraska*

viewpoint. First, most post-menopausal symptoms, they say, are psychosomatic. The children are leaving home and taking the grandchildren to live in California. The husband is at the peak of his career, but the wife has no usefulness, and no place except a rocking chair by the fire, and even this is being taken away. These patients really need physician counseling and increased activity rather then estrogens. Secondly, estrogens have not been proven to reduce atherosclerosis. The serum cholesterol may be reduced, but there is no improvement in the long term morbidity of individuals who had an episode of myocardial infarction when they are given estrogen. There is little difference in the experience of men versus post-menopausal women of the same age so far as in the incidence of coronary artery disease. Thirdly, does estrogen really help osteoporosis? This bone disorder does not appear at an earlier age in women with a surgical menopause, the loss of height in osteoporosis may cease spontaneously, and a high calcium intake itself may relieve the symptoms and prevent further fractures. Other factors such as race, the fluoride content of water, and thyrocalcitonin are involved in bone metabolism. Fourthly, the opponents do not deny that estrogens may retard genital atrophy, but point out that all women are different. Anyone who has compared Raquel Welch with Kate Smith could hardly argue with this contention. Vaginal cytology shows that while about half of all women show progressive vaginal atrophy with the passing years, it is only complete in 20 per cent. Of the other half, most show a moderate persistent estrogenic activity, and in about 10 per cent of all post-menopausal women, at least as measured by vaginal cytology, levels of estrogen activity are high.

Finally, estrogens do cause growth of breast tumors, do, if given on a continuous basis, lead to adenomatous hyperplasia of the endometrium which may be a premalignant lesion, and clearly cause activity and growth in uterine leiomyomas and in endometriosis.

The whole series of arguments might perhaps be summarized by the opponents who say that post-menopausal women don't need hormones—they will be fine if they simply go out and jog around the block every day, while those in favor of estrogen reply that unless the woman takes estrogen she won't feel like jogging around the block.

After all this, what should we do? There seems to be little dispute that almost all women who have a premature or surgically induced menopause prior to the natural menopause do benefit from estrogen therapy. A great many women are on oral contraceptives and will be continuing this form of therapy to age 45 or 50. But—what should we do at this point?

It is safest to say that: with our present state of knowledge, and certainly with our presently available drugs, the results are not in from the outlying precincts; and there is no clearcut answer. If I were to make some dogmatic statement, I would only be backing up the old observation that "an expert is never in doubt, but frequently in error." In my own mind, I do believe that long term steroid replacement therapy offers many benefits to most women. It does have a few drawbacks, which are not substantial.

TABLE I

PROGRAMS

1. Continuous estrogen
2. Continuous estrogen with cyclic progesterone
3. Cyclic estrogen and progesterone
   a. Continuous progesterone
   b. Late cycle progesterone
4. Cyclic Estrogen
5. Estrogen and Androgen

There are five possible dosage programs represented in Table I. In selecting a possible approach it should be noted that present evidence suggests that the progestational agents may induce abnormalities of glucose tolerance, elevate triglycerides and cholesterol, so that at present estrogens alone or estrogens with limited dosages of progesterone would seem best. Continuous estrogen may cause considerable breast tenderness, but more importantly it causes progressive endometrial buildup with irregular and sometimes heavy uterine bleeding. At least if the uterus is present it seems not to be a wise choice.

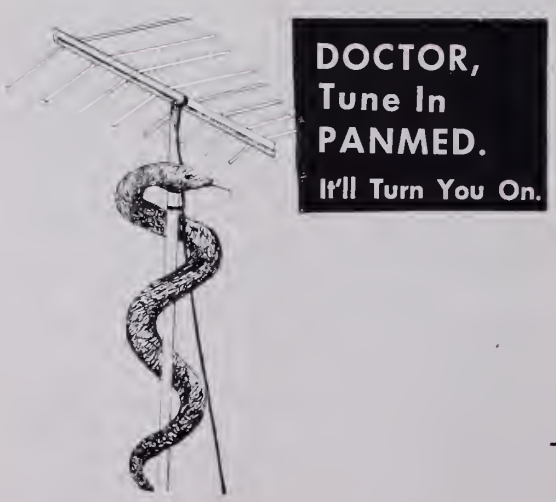
Continuous estrogen with cyclic progesterone, for example 10 mg. of medroxyprogesterone acetate for 3 to 5 days each month,

will induce cyclic bleeding, and interrupt the pattern of the continuous estrogen effect. It probably is not a large enough dose of progesterone to induce a normal secretory endometrium. The cyclic estrogen and progesterone therapy are represented under 3. a., "Continuous progesterone," by the combined oral contraceptives and under 3. b., "late cycle progesterone," by the sequential contraceptives. The latter are satisfactory as steroid replacement therapy, but monthly bleeding may be considerable. Cyclic estrogen alone, that is estrogen administered for perhaps three weeks out of each month, has been in our hands the most satisfactory therapy. The dosage can be reduced, for example, to someplace between 0.1 and 0.5 mg. of Stilbestrol. This will induce satisfactory changes in the vaginal mucosa and is apparently adequate for the beneficial effects concerning atherosclerosis and osteroporosis, but usually induces only one to two days of minimal spotting during the week off the drug, or in some instances no bleeding at all. The androgens, used with estrogen, do have beneficial effects in nitrogen retention and a feeling of well being, but may also have undesirable side effects of masculinizing changes and changes in libido.

In the choice of drugs, it should be remembered that oral dosage is easier to regulate, and certainly less expensive than parenteral drugs. The substituted progesterones are effective orally. Stilbestrol is a fully effective and very inexpensive estrogen. While our knowledge is still somewhat limited, it is also clear that the effects of an estrogen, on, for example, the vaginal mucosa, the endometrial lining, the serum cholesterol, and calcium balance are not all equivalent, and one—for example the pap smear—may certainly not reflect another. Substituted estrogenic compounds, which maintain the reproductive tissues, have beneficial effects in the prevention of atherosclerosis and osteoporosis, and cause no significant endometrial changes, no cyclic bleeding, and no significant breast effects are what we need. Presumably some day such drugs will be available.

In the meantime, my own preference is the use of somewhere between .1 and .5 mg. of Stilbestrol beginning on the first day of every month and continuing from 21 to 24 days. Low dose sequential oral contraceptives are a satisfactory substitute, with the disadvantage that more uterine bleeding is induced.

It is almost redundant to say that this is but one facet in the total management of the patient who may need support, superficial psychotherapy, encouragement to lead an active life, and certainly yearly examinations and cytologic studies. Thank heavens women aren't fertile until age 95, but perhaps we can make them feel as if they might be any day.



Be Sure To Watch

"Gastric Ulcer—Benign or Malignant"

January 28 (KETV) and February 2 (WKPC)

(See page 25 for details)



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to give her new baby all the love
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She needs time for her husband . . .
and for herself as well . . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
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Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophtholein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.



References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

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Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
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The Under-Utilization of Extended Care Facilities Of Hospitals in Kentucky*

Over the past few years hospitals in Kentucky have been encouraged to construct extended care facilities (ECF's). A number did so with federal matching money, and others converted existing facilities to that purpose. To our knowledge 11 hospitals provided new construction and two others converted existing facilities, one of which was in Harrodsburg and was subsequently inactivated because of administrative and other difficulties. The other conversion was at Murray. A newly constructed, 35-bed unit at Greensburg was closed November 15, 1969, for various reasons. The total public investment in new, hospital extended care facilities in Kentucky amounts to the order of $7,000,000.

As the result of increasing complaints from hospitals in early 1969, the Kentucky Medical Association, the Kentucky Hospital Association, and various program directors became concerned with difficulties being experienced by hospital based ECF's in complying with the requirements and regulations of both Title XVIII and XIX. We are well aware that ECF's not connected with hospitals have been experiencing many of the same difficulties as those found in hospital connected units. Initially the most disturbing element sifted out of the comments of the hospitals was that of low utilization of ECF beds to the extent that some beds were standing empty while a need existed for both nursing home and acute beds. We felt it unconscionable to ignore comments emanating from hospital administrators, boards of trustees and medical staffs who were doing all in their power to provide services to their communities under the handicaps, so to speak, of dealing with various governmental provider programs while at the same time having to meet the needs of the people in their communities who are, for the most part, uninitiated and unknowledgeable regarding the intricacies involved in the Title XVIII and XIX programs as well as other governmental offerings from the federal level.

Moreover program directors in the Department of Health and the Title XVIII intermediary were, and have continued to be, under constant pressure to make favorable decisions in cases which do not meet the guidelines of federal and state statutes and various rules and regulations which have been promulgated primarily in connection with the Title XVIII extended care benefit program.

The results of the meetings and a field trip sponsored by the Kentucky Medical Association and the Kentucky Hospital Association are published here for your information. KMA wishes to express its appreciation to Mr. Hasty Riddle, executive vice president of the Kentucky Hospital Association for compiling this report.

Action

With this situation serving as a background, we suggested a meeting, which was held on July 23, 1969, with the Kentucky Commissioner of Health and his program directors; administrators of hospitals having ECF's and several members of their medical staffs; representatives of Title XVIII and XIX; a representative from the Region III HEW Medical Director's Office; also a Region III representative of the Hill-Burton program; as well as a representative of the Region III Bureau of Health Insurance, all from Charlottesville. The program representatives present were most cooperative and felt there was an urgent need for more definitive action somewhere along the line.

The results of this exploratory meeting indicated that the overall problem of hospitals with ECF's was serious to the point that some early action at the uppermost levels of federal and state government was necessary. Following the meeting we asked the hospital representatives present to furnish us in writing a brief outline of the problems which they were encountering.

Follow-up action took place on October 29-30, 1969. This was a joint meeting of representatives from KMA, KHA, Kentucky Department of Health, the Title XVIII intermediary, HEW and SSA. A field trip to the Fleming County Hospital ECF and Harrison Memorial Hospital ECF was made on October 29 and included representatives of the above-named organizations except the Title XVIII intermediary. We met with the administrator, board of trustees, and medical staff at each institution.

Following the field trip to Fleming County Hospital and Harrison Memorial Hospital ECF's, those at the October 29-30 meeting were invited to prepare written comments which would serve as a part of this summary, and at the same time provide *unedited* views which would be valuable in the development of solutions to the problems of hospitals with ECF's.

The consensus of the group at a final meeting on October 30 was as follows:

1. In order to limit the problem area to manageable means, it was decided that initial concentration should be directed to solving the problems of the twelve hospitals having extended care facilities.
2. Blue Cross and other third party carriers should be requested to re-examine their contracts and systems of providing coverage to their subscribers to determine if there might be possibilities of writing contracts which in the future would strengthen the extended care concept in hospital facilities.
3. The Kentucky Medical Aossociation should be urged to study the Utilization Review Committee concept particularly as it involves hospitals and physicians in communities which have small numbers of physicians on hospital medical staffs.
4. The intermediary for Title XVIII and the program directors of Title XIX should take immediate steps to insure that the medical care institutions, as well as those administering the programs, know and understand their responsibilities.
5. Since this whole matter comes under the cognizance of the Comprehensive Health Planning Council in Kentucky, it should be referred to that body with a suggestion that a special committee or other group be appointed to study the whole picture of need and use of extended care facilities in the Commonwealth.

Summary

It would be extremely difficult and time consuming to summarize the views expressed by so many individuals into specific and detailed recommendations, which in fact was not the original intent of our undertaking.

Prior to the completion of this report, KMA and KHA representatives informally agreed to present verbally our views to the Health Facilities Task Force of the Comprehensive Health Planning Council on November 12, 1969. This was done primarily to take advantage of a meeting of the task force and council on that date. The force had been kept advised of our activities. Subsequently on November 12, the task force reported our activities to the Comprehensive Health Planning Council which took official note of the problem. A copy of this report will be furnished the Health Facilities Task Force.

A multitude of factors enter into this whole picture. Some of the more important ones involved are:

A. The Kentucky licensure statute which provides only for licensure of hospitals and nursing homes and not extended care units per se;

B. Stringent Title XVIII quality of facility regulations on the point of extended care facilities which in effect negate nursing home, and custodial care as generally known before the days of Medicare;

C. Utilization review, particularly in hospitals in communities having a small number of physicians;

D. Burdensome and time consuming administrative systems which are difficult to understand and to comply with, particularly in the light of personnel turnovers in our institutions;

E. A multiplicity of government programs with which an institution has to deal, all different administrative procedures as well as reimbursement systems;

F. Financial problems involving insufficient cash flow because claims are rejected and numerous ECF beds are unfilled;

G. Lack of knowledge or misunderstanding of the public as to what their benefits are under Medicare, Medicaid, and other programs;

H. Empty ECF beds in communities which have a tremendous need for such facilities;

I. The undesirable result of the situation concerning ECF's is that hospitals now are more reluctant to build this type of facility in the light of the present situation here in Kentucky; and,

J. The term ECF is new and subject to different definitions by many people. This example points up the fact that there is a problem involving semantics when the subject of different levels of care is discussed; i.e., acute bed, extended care bed, nursing home bed, and custodial care bed. Also the term intermediate care is being used which further confuses the issue. We also find that a new term has evolved, "non-covered care" which seems to be replacing the term custodial care.

We see this ECF empty bed problem as one which can be solved with changes in federal and state statutes, their regulations, and other policy and fiscal decisions which obviously must be taken at the national level; plus a solution to problems related to the community and facility medical staffs.

It is obvious that the present Title XVIII program needs an intermediate level of care following or below the extended care level as now being administered. The program as it has developed has had the practical effect of eliminating a level of care which was previously understood as that provided in a nursing home.

The seriousness and immediacy of the present situation cannot be overstated. Our hospitals with ECF's in several instances are in dire financial straits. One hospital to our knowledge is losing an estimated $3,000 per month while at the same time two-thirds of its 40 extended care beds remain idle.

The public will not long stand still for this type of administration. We sincerely hope that our message is understood by all those in responsible positions and that all the benefits of extended care facilities envisioned several years ago will not go for naught while we fight our way through red tape and other barriers to the development of sound decisions and programs in this regard.

The need is urgent—the time is now!

The Kentucky Medical Association and the Kentucky Hospital Association appreciate the cooperation of all officials and organizations which lent their assistance to this project.

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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the dru should be discontinued with the ap pearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk t minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma

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s, Stevens-Johnson syndrome, ell's syndrome (toxic necrotizing dermolysis), or a generalized ergic reaction similar to serum kness may occur and require manent withdrawal of medication. Agranulocytosis can occur denly in spite of regular, repeated mal white counts. Stomatitis d, rarely, salivary gland enlargent may require cessation of treatnt. Such patients should not eive subsequent courses of the g. Vomiting, vertigo and languor y occur. Leukemia and leukemoid ctions have been reported. While definitely attributable to the g, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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To Be Alert and Helpful

LAST fall when there was before our electorate an amendment to have our Legislature meet annually rather than every second year, one of our young medical wags here in Louisville opined that he'd favor, instead of a 60-day session every two years, a two-day session every sixty years. Maybe an extreme view, but considering the activity we as physicians must generate for every legislative session, we are generally happier to have it come every two years than twice as often. Of all bills presented a very large percentage always pertain to health matters and we simply must watch carefully to differentiate the good from the bad.

Bureaucracy is a nasty word which is used all too frequently and too loosely by most of us. Our own personal observations over several years of contact with our elected officials, including senators and representatives, is that they are, generally, men and women of above average intelligence and vision; that they honestly try to serve the best interests of our citizens. To eliminate partisanism and self interest entirely is asking too much, but they are by no means motivated chiefly by a desire for financial gain nor prestige.

The state and local legislative committees of the KMA have in the last few years been increasingly active in trying to favorably influence health legislation in the state, and have been considerably successful. We must continue our efforts, and the time for close attention to what may go on is now. In Louisville, we devote the December meeting of our county society to entertaining locally elected legislators with the purpose of getting to know them better and assuring them of our interest and our readiness to be of what help we can toward a better understanding of measures presented for consideration, especially with regard to health. Other larger county societies follow a similar plan. In smaller communities it becomes the responsibility of physicians to know and keep good rapport with their local representatives.

While the Legislature is in session personal visits at home or in Frankfort have proven decidedly helpful; we may well afford the time and tact required in order to assure the best results. Such interest in the past has been effective in a very gratifying manner. We nearly always find our visits and viewpoints graciously received.

The chairman of our committee on Legislative Activities for State Affairs is Fred C. Rainey, M.D., Elizabethtown. He will try as usual to keep the membership of KMA informed regarding proposed bills, and the opinion of his committee regarding them, in ample time for us to inform our senators or representatives regarding the necessity, urgency or advisability of such legislation.

It is reasonably certain that a bill will be introduced concerning restructure of the State Board of Health. In the November issue of The Journal we outlined the position of the Executive Committee and of the members of the Board of Health on this matter. There has been no change in attitudes so far as we know and it is our information that our suggestions are generally accepted by the Legislative Research Commission.

Medical licensure is a subject of considerable interest and discussion. It has been proposed that a general Board of Licensure be established including medical with all other professions and businesses. We have favored a Board of Medical Licensure separate from the Board of Health composed entirely of physicians, with the central office at KMA Headquarters or at the State Health Department. This was stated in our joint proposal to the Legislative Research Commission and so far as we know had their approval.

Limited license for interns and even for senior medical students has been proposed. A resolution recommending limited license for in-

terns was approved by the House of Delegates. Whether this can be accomplished by regulation of the Board of Health or legislation will be required has not been decided but it may well appear on the Legislative calendar.

Much has been said and written in the daily press regarding our policies with respect to licensing graduates of foreign medical schools. Pressure has been exerted to abridge our present rules in order to allow these applicants to practice in selected localities and some such proposal may well be presented to the Legislature. The present requirements by which these applicants are processed are generally adequate and certainly not too restrictive. We must satisfy ourselves first that they are physicians; that is not always easy and we have been misguided in that respect more than once. They must meet certain minimal educational standards in Medicine and have some approved postgraduate training. They must pass medical examination for even limited or restricted license. They must meet the immigration standards of their native country and ours, have appropriate visas and, if candidate for full license, must be a citizen or in certified process of becoming a citizen.

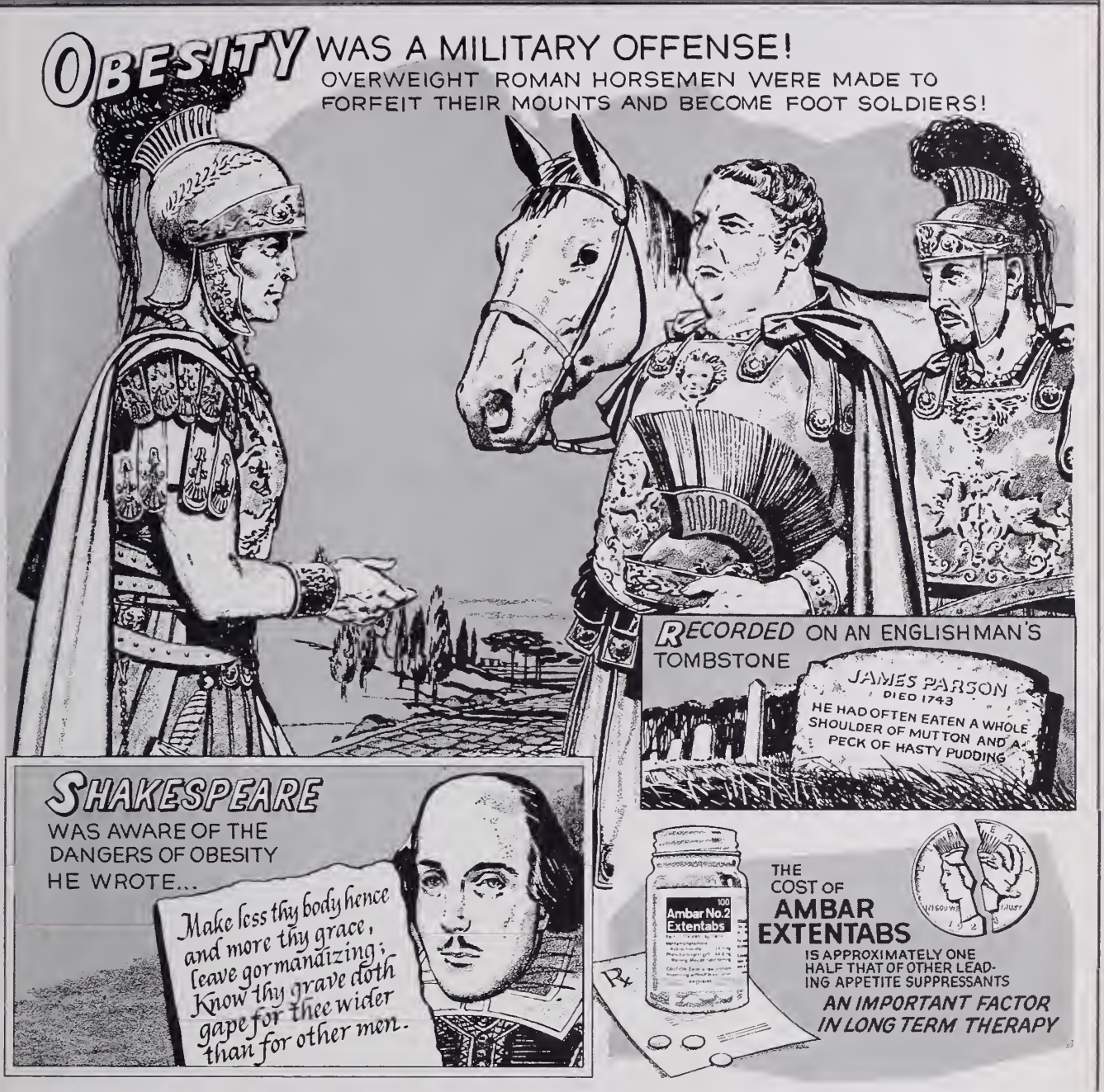
These standards are simple and used generally by most states, yet we are repeatedly pressed to modify or suspend certain provisions for individuals. It is quite understandable that a community without adequate medical coverage may get impatient and weary of the "due process" and charge ineptness or bureaucracy to our Boards, yet we have had very tragic experiences from short-circuiting our own established standards; we recognize our responsibility for protecting the health care of our people. If one of us chose to go to another country to practice medicine, would we expect established regulations to be altered to accommodate our convenience and preference? Most likely not.

Pertinent to this is the fact that we now enroll about 180 freshmen students each year in our two medical schools, and beginning with the opening of the new facility at the University of Louisville in September '70, this number will exceed 200. We are in an increasingly better position to supply physicians to our smaller towns and rural communities.

Other proposals to be expected will pertain to air and water pollution, perhaps some revision of the plumbing code, tuberculosis and venereal disease control, hospital planning and construction and regulations relating to other varied health facilities. We have no preformed convictions except in relation to reconstruction of the Board of Health and a separate Medical Licensure Board. It is, however, our privilege and duty to keep informed and render such advice and help as we may in formulating health policies for the next two years or longer.

SAM A. OVERSTREET, M.D.

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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ORGANIZATION SECTION

Ex-Vice-President of KMA, Dr. Rex E. Hayes Dies

Rex E. Hayes, M.D., 61, died Wednesday morning, December 10 in Glasgow. Death was attributed to a heart attack.



Doctor Hayes

Doctor Hayes was very active in the affairs of KMA. He served as its vice-president from the western region of the state from 1959 to 1960. A Trustee from the Sixth District, Doctor Hayes was chairman of the Board of Trustees from 1966-67.

Born at Gamaliel in 1908, Doctor Hayes attended Western Kentucky State College and the University of Louisville where he received his M.D. degree in 1933. After serving a rotating internship and two years residency in medicine at Louisville General Hospital, he entered the private practice of medicine in Glasgow in 1936.

Doctor Hayes served four years in the Medical Corps of the U.S. Army and was discharged in 1946 as a major. Since his discharge, he has practiced in Glasgow and served on the staff of the T. J. Samson Community Hospital. Doctor Hayes was also chairman of the Barren County Health Department.

Interim Mtg. Speakers, Panels To Discuss Medicine In 70's

Physicians attending the 21st annual KMA Interim Meeting at Kentucky Dam Village State Park, April 8-9, will hear state and national speakers discuss timely topics on "Kentucky Medicine in the 70's", the theme of this year's session.

A dinner on Wednesday evening, April 8, will open the meeting. At that time, a top official of the American Medical Association will speak on "Health Care in the 70's."

On Thursday morning two panel discussions will be presented. The first, on peer review, will deal with the national outlook, the consumer's viewpoint and KMA's guidelines for peer review.

Walter I. Hume, Jr., M.D., Louisville, chairman of the KMA Committee on Medical Education, will moderate the second panel which will deal with the topic "A Profile of the Physician's Assistant in Kentucky." The training and utilization of these assistants and other individuals in this new category of health personnel will be discussed.

The two-day meeting will close with a luncheon session at noon Thursday, April 9. J. Ed McConnell, president of Kentucky Physicians Mutual, Inc. and Blue Cross Hospital Plan, Inc. will be the featured speaker at this part of the program.

In addition to the outstanding program planned for the Interim Meeting, an Orientation Program for new members is scheduled. The Woman's Auxiliary to KMA and the KMA Board of Trustees will also be meeting during this session.

Oral Cancer Symposium Presented By U of L On February 7

The department of surgery of the University of Louisville School of Medicine will hold a symposium on "Treatment of Oropharyngeal Cancer" Saturday, February 7, according to Condict Moore, M.D., director of the Louisville Oral Cancer Diagnostic Program.

The symposium, beginning at 8:30 a.m., will be held in the Rankin Amphitheatre at General Hospital, Louisville. The symposium is open to all physicians, house staffs, dentists and related groups. Credit hours will be awarded by the American Academy of General Practice.

Participants in the program include Elliot W. Strong, M.D., Memorial Hospital, New York; Paul Chretien, M.D., National Institute of Health, Bethesda, Md.; Edward C. Hinds, D.D.S., M.D., University of Texas, Houston; Donald A. Shumrick, M.D., University of Cincinnati; Richard King, M.D., College of Virginia, Richmond, and Ralph Scott, M.D., University of Louisville, Louisville.

KMA Headquarters Office Gets New Street Name

The KMA Headquarters Office has not moved; it has just changed the street name where it is located. Effective on December 27, 1969, Janet Avenue officially became Ephraim McDowell Drive.

Named after the pioneer surgeon of Kentucky, Ephraim McDowell Drive was brought about by the efforts of the KMA Memorials Commission. The headquarters staff urges you to make this change and direct all correspondence to 3532 Ephraim McDowell Drive.

Ephraim McDowell, who has been called "the father of abdominal surgery," was the first to remove successfully an ovarian tumor, which he did on December 25, 1809 in his home at Danville. The KMA purchased and still operates the McDowell House there.

Twenty-five Ky. Doctors Attend AMA Convention in Denver

According to the records of the AMA, 25 Kentucky physicians attended the AMA Clinical Convention in Denver November 30 through December 3.

A complete list of those attending follows:

John Ammon, M.D., Florence
Henry B. Asman, M.D., Louisville
Thomas H. Biggs, M.D., London
Marvin A. Bowers, Jr., M.D., Louisville
Charles G. Bryant, M.D., Louisville
W. Neville Caudill, M.D., Louisville
Walter L. Cawood, M.D., Ashland
Donald E. Edger, M.D., Lexington
Hoyt D. Gardner, M.D., Louisville
J. Thomas Giannini, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
Kenneth P. Haywood, M.D., Earlington
L. C. Hess, M.D., Florence
John S. Llewellyn, M.D., Louisville
Robert C. Long, M.D., Louisville
O. B. Murphy, M.D., Lexington
Casey J. Purdy, M.D., Gilbertsville
John C. Quertermous, M.D., Murray
Charles C. Rutledge, M.D., Hazard
Joseph Schickel, M.D., Burkesville
David B. Stevens, M.D., Lexington
Wellington B. Stewart, M.D., Lexington
Ben E. Watson, M.D., Lexington
William R. Willard, M.D., Lexington
Carroll L. Witten, M.D., Louisville

KEMPAC Support in Races For State Legislature Reported

The Kentucky Educational Medical Political Action Committee was able to provide effective candidate support in the 1969 state legislative races, due to the record number of KMA members joining KEMPAC, according to C. Kenneth Peters, M.D., Louisville, chairman of the KEMPAC Board of Directors.

KEMPAC's record of candidate support in both the primary last May and in the November 4 general election was evenly divided between the two parties. There was considerably more interest this year by physicians candidate support committees in these races, according to Doctor Peters.

The KEMPAC Board chairman said that in order to secure KEMPAC funds for candidate support there must be an agreement between local physicians and the KEMPAC Board's committee on the candidate. The local candidate support committee must raise at least as much as is requested from the KEMPAC Board for its candidates in order to qualify for assistance.

"In 1970 we will elect seven Kentucky congressmen. Congressional campaigns are expensive—often running well into five figures," Doctor Peters said. "The members of our Board, in view of the importance of the 1970 election to our country and to our state in making our influence felt, urge physicians to promptly remit their 1970 family membership dues. Since there is only one KEMPAC membership classification, both a physician and his wife become members for an annual dues rate of $35—which includes dual AMPAC membership."

PANMED Adds 4 New Programs

Four new programs have been scheduled in the PANMED television series, according to Thomas L. Heavern, Jr., M.D., Highland Heights, chairman of the Committee on Educational Television.

The programs, beginning on KETV-TV January 21, will deal with nursing, medicine, dentistry and pharmacy. The complete schedule of PANMED programs appears on the Continuing Educational Opportunities page (25).

O.T. Amnesty Year Is 1970

The Kent Occupational Therapy Association is trying to locate therapists in the state who have dropped their membership and are not working. The Association announces that 1970 is an amnesty year and any therapist requesting information is urged to contact Mrs. Beverly S. Abraham, O.T.R., VA Day Center, 1405 West Broadway, Louisville 40201.

In Memoriam

ALEXANDER J. ALEXANDER, M.D.
Lexington
1907-1969

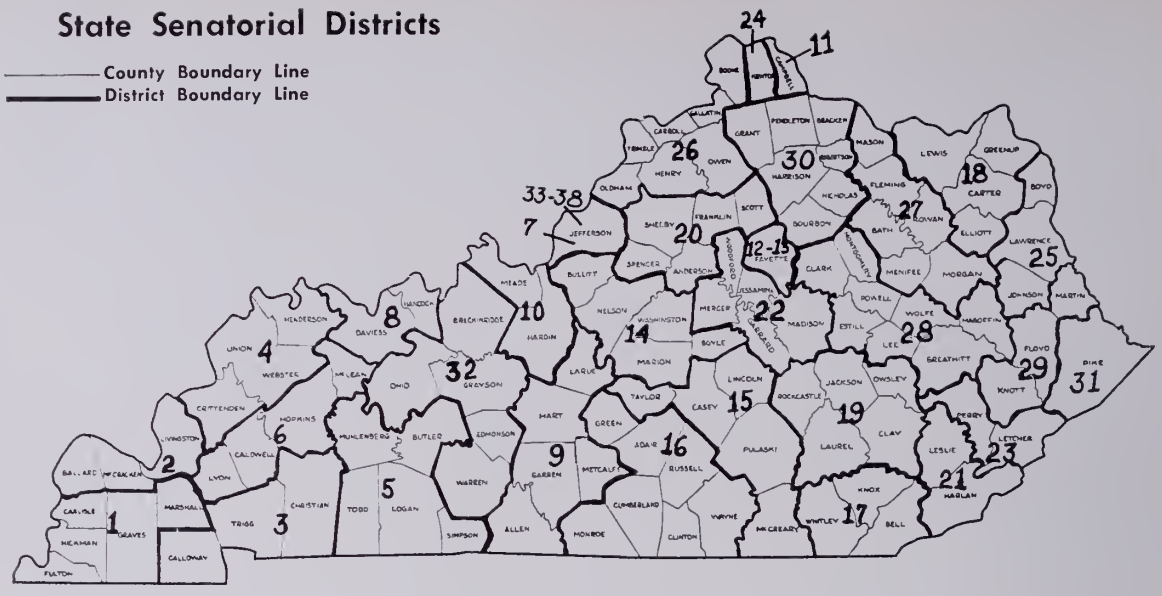
Alexander John Alexander, M.D., Lexington, died November 18 at the age of 62. A 1934 graduate of Johns Hopkins University School of Medicine, Doctor Alexander was a pediatrician.

He completed his internship at Columbia Presbyterian Hospital and the Union Memorial Hospital, Baltimore. During World War II, Doctor Alexander served with the U.S. Army Medical Corps. A member of the American and Kentucky Pediatrics Societies, Doctor Alexander was very active in civic affairs in Kentucky.

REX E. HAYES, M.D.
Glasgow
1908-1969

Rex E. Hayes, M.D., 61, a general practitioner from Glasgow, died December 10. Death was attributed to a heart attack. A 1933 graduate from the University of Louisville Medical School, Doctor Hayes was KMA vice-president from 1959-60 and chairman of the Board of Trustees from 1966-67. He also served as the chairman of the Barren County Health Department.

State Senatorial Districts



Senate and House Rosters Listed For 1970 Kentucky Assembly

Listed below are the 38 senators and 100 representatives who will participate in the 1970 Kentucky General Assembly. Their names, addresses and districts are included, along with maps showing the counties they will serve.

The 1970 Senate is composed of 23 Democrats and 15 Republicans. Nine of the 38 senators are new members. In the House there will be 72 Democrats and 28 Republicans. Of the total membership of the House, 49 representatives are new.

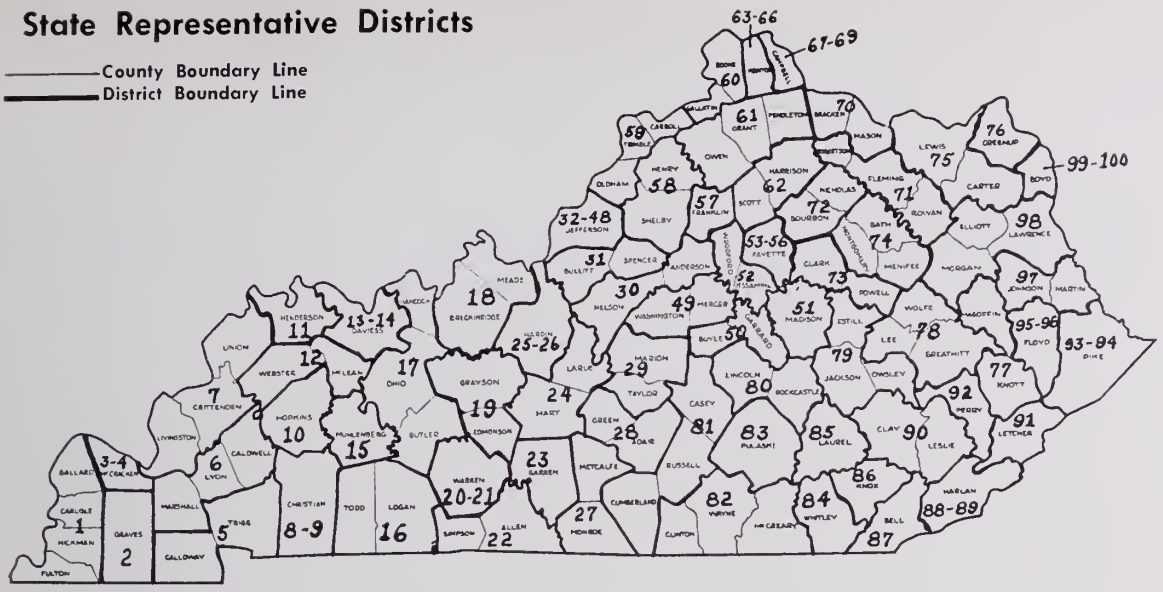
Kentucky General Assembly 1970 Senate Roster

District	Home County	Senators
1	Graves	Carroll Hubbard, Jr. (D), Mayfield
2	McCracken	Tom Garrett (D), Paducah
3	Christian	Pat M. McCuiston (D), Pembroke
4	Henderson	William L. Sullivan (D), Henderson
5	Todd	Carl T. Hadden, Sr. (D), Elkton
6	Hopkins	William A. Logan (D), Madisonville
7	Jefferson	Richard Chin (R), Louisville
8	Daviess	Delbert S. Murphy (D), Owensboro
9	Allen	J. C. Carter (R), Scottsville
10	Hardin	Walter "Dee" Huddleston (D), Elizabethtown
11	Campbell	Donald L. Johnson (R), Ft. Thomas
12	Fayette	C. Gibson Downing (D), Lexington
13	Fayette	Robert D. Flynn (R), Lexington
14	Nelson	William R. Gentry, Jr. (D), Bardstown
15	Pulaski	Norman E. Farris (R), Science Hill
16	Clinton	James A. Hicks (R), Albany
17	Whitley	Charles B. Upton (R), Williamsburg
18	Lewis	George M. Plummer (R), Vanceburg
19	Clay	Fred F. Bishop (R), Manchester
20	Shelby	Mack G. Walters (D), Shelbyville
21	Harlan	James C. Brock (R), Harlan
22	Mercer	Edwin Freeman (D), Harrodsburg
23	Perry	Pearl Strong (D), Ary
24	Kenton	Clyde Middleton (R), Ft. Mitchell
25	Johnson	Wendell Van Hoose (R), Tutor Key
26	Carroll	Thomas O. Harris (D), Worthville
27	Morgan	Joe D. Stacy (D), West Liberty
28	Powell	B. E. Billings (D), Stanton
29	Floyd	Clifford B. Latta (D), Prestonsburg
30	Harrison	Wilson Palmer (D), Cynthiana
31	Pike	Francis M. Burke (D), Pikeville
32	Warren	Ray B. White (R), Bowling Green
33	Jefferson	Mrs. Georgia M. Davis, (D), Louisville
34	Jefferson	Walter S. Reichert (R), Louisville
35	Jefferson	Romano L. Mazzoli (D), Louisville
36	Jefferson	Scott Miller, Jr. (R), Louisville
37	Jefferson	Henry Beach (D), Louisville
38	Jefferson	Nicholas Baker (D), Louisville

Kentucky General Assembly 1970 House Roster

District	Home County	Representatives
1	Carlisle	Ralph Graves (D), Bardwell
2	Graves	Lloyd Clapp (D), Wingo
3	McCracken	Julian M. Carroll (D), Paducah
4	McCracken	David Carter (D), Paducah
5	Calloway	E. Guy Lovins (D), New Concord
6	Marshall	Richard H. Lewis (D), Benton
7	Union	Joseph McBride (D), Waverly
8	Christian	John O. Hardin, III (D), Hopkinsville
9	Christian	James E. Bruce (D), Hopkinsville
10	Hopkins	Omar Parish (D), Madisonville
11	Henderson	Gross C. Lindsay (D), Henderson
12	Webster	Joe Head (D), Providence
13	Daviess	Charles S. Wible (D), Owensboro
14	Daviess	Donald J. Blandford (D), Philpot
15	Muhlenburg	Billy R. Paxton (D), Central City
16	Logan	Homer B. Dorris (D), Russellville
17	Ohio	Theron Kessinger (R), Beaver Dam

State Representative Districts



18	Breckinridge	Mrs. H. W. (Marjorie) Tobin (D), Harned
19	Edmonson	Walter F. Davis (R), Brownsville
20	Warren	George T. Massey, Jr. (D), Bowling Green
21	Warren	Edward G. Brown (D), Bowling Green
22	Allen	T. C. Simmons (R), Scottsville
23	Barren	Walter A. Baker (R), Glasgow
24	Larue	R. K. Keith (R), Hodgenville
25	Hardin	Jon E. Rickert (D), Elizabethtown
26	Hardin	Joseph W. Prather (D), Vine Grove
27	Metcalfe	Wallace Bartley (R), Summer Shade
28	Adair	O. A. Durham (R), Columbia
29	Taylor	Herman W. Ratliff (R), Campbellsville
30	Nelson	Bernard Keene (D), Bardstown
31	Bullitt	Leo Bleemel (D), Mt. Washington
32	Jefferson	E. Bruce Blythe, Jr. (R), Louisville
33	Jefferson	Peter Conn (D), Louisville
34	Jefferson	Wilson W. Wyatt, Jr. (D), Louisville
35	Jefferson	Carl A. Nett (D), Louisville
36	Jefferson	Clarence R. Miller (D), Louisville
37	Jefferson	M. J. Kleier (D), Louisville
38	Jefferson	Dexter S. Wright (R), Louisville
39	Jefferson	Tom Ray (D), Louisville
40	Jefferson	George R. Siemens (D), Louisville
41	Jefferson	Mrs. Mae Street Kidd (D), Louisville
42	Jefferson	Hughes E. McGill (D), Louisville
43	Jefferson	Norbert Blume (D), Louisville
44	Jefferson	James R. Yocum (D), Louisville
45	Jefferson	Mrs. Dorothy Priddy (D), Louisville
46	Jefferson	Robert F. Hughes (D), Louisville
47	Jefferson	Edward L. Holloway (R), Louisville
48	Jefferson	Eugene P. Stuart (R), Prospect
49	Washington	James I. Osborne (R), Springfield
50	Boyle	P. Joe Clarke (D), Danville
51	Madison	Dwight Wells (D), Richmond
52	Woodford	James T. Alexander (D), Versailles
53	Fayette	William G. Kenton (D), Lexington
54	Fayette	Bart N. Peak (D), Lexington
55	Fayette	David L. VanHorn (D), Lexington
56	Fayette	William H. McCann (D), Lexington
57	Franklin	William P. Curlin, Jr. (D), Frankfort
58	Shelby	Ralph Mitchell (D), Shelbyville
59	Carroll	W. J. Louden (D), Carrollton
60	Boone	Dan J. Roberts (D), Walton
61	Grant	E. T. Reed (D), Corinth
62	Harrison	John Swinford (D), Cynthiana
63	Kenton	Carl J. Ruh (D), Ft. Mitchell
64	Kenton	Phillip E. King (D), Taylor Mill
65	Kenton	John J. Isler (D), Covington
66	Kenton	Carl Mershon (D), Covington
67	Campbell	James E. Murphy (D), Newport
68	Campbell	William Donnermeyer (D), Bellevue
69	Campbell	Arthur L. Schmidt (R), Cold Spring
70	Mason	Austin Wenz (D), Dover
71	Rowan	Sherman R. Arnett (D), Clearfield
72	Bourbon	Brooks Hinkle (D), Paris
73	Clark	Glenn White (D), Winchester
74	Montgomery	Mrs. Nell Guy McNamara (D), Mt. Sterling
75	Carter	James A. Davis (R), Grayson
76	Greenup	W. Terry McBrayer (D), Greenup
77	Magoffin	Darvin Allen (D), Royalton
78	Breathitt	Russell Reynolds (D), Jackson
79	Jackson	Lloyd McKinney (R), McKee
80	Lincoln	Wm. Harold DeMarcus (R), Stanford
81	Casey	Hershel Brown (R), Liberty
82	McCreary	Archie Brown (R), Stearns
83	Pulaski	Lavey Floyd (R), Pointer
84	Whitley	Clifford Sharp (R), Williamsburg
85	Laurel	Gene Huff (R), London
86	Knox	Howard West (R), Artemus
87	Bell	Denver C. Knuckles (R), Middlesboro
88	Harlan	Bert Ed Pollitte (D), Harlan
89	Harlan	Glenn R. Freeman (D), Cumberland
90	Clay	John E. White (R), Manchester
91	Letcher	Raymond Collins (R), Whitesburg
92	Perry	Johnnie M. Salyers (D), Bulan
93	Pike	Fon Deskins (D), Elkhorn City
94	Pike	Marrs Allen May (D), Pikeville
95	Floyd	W. J. Reynolds (D), Allen
96	Floyd	T. P. Reynolds (D), Beaver
97	Martin	L. T. Hardin (R), Inez
98	Morgan	Joe W. Haney (D), West Liberty
99	Boyd	Thomas E. Chapman (D), Rush
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KENTUCKY MEDICAL ASSOCIATION

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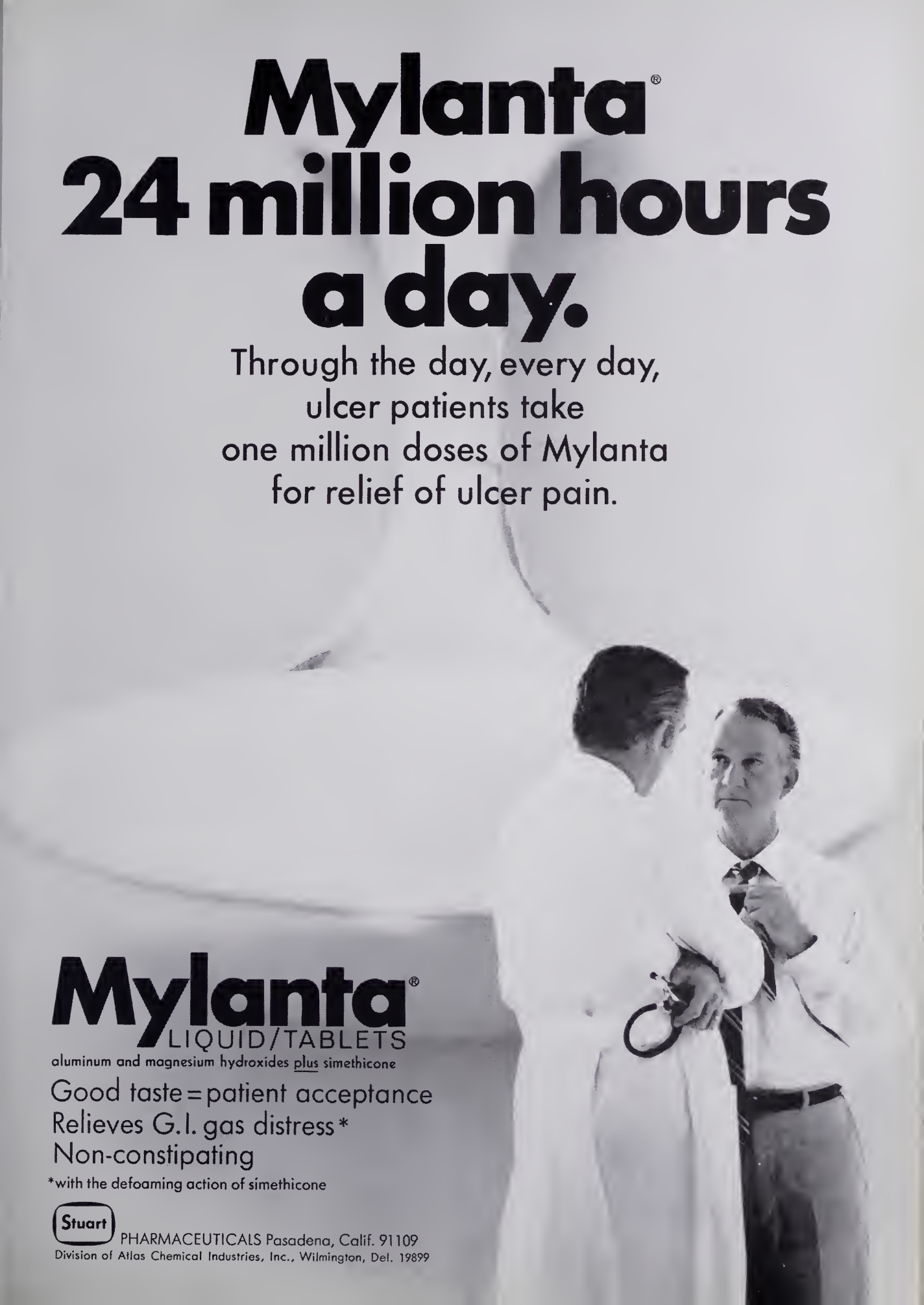
BUYERS GUIDE

JANUARY BUYERS GUIDE FOR JOURNAL OF KMA 1970

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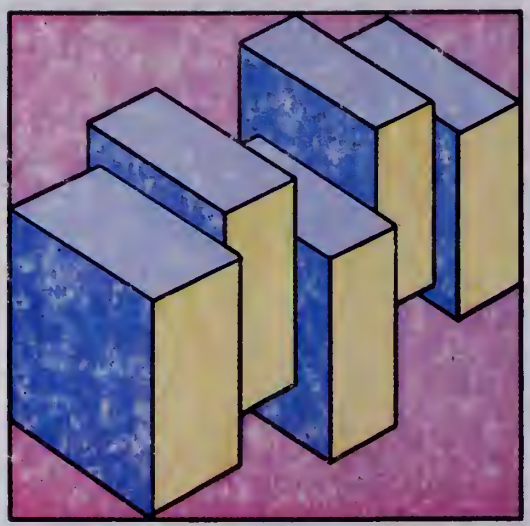
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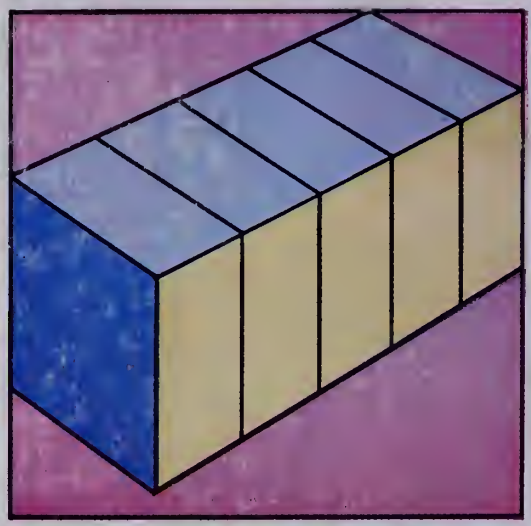
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to emotional harmony

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INDICATIONS: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
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WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
PRECAUTIONS: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been estoblished clinically.
ADVERSE REACTIONS: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido--all infrequent and generally controlled with dosage reduction; changes in EEG potterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

with the aid of antianxiety

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The Journal of The KENTUCKY Medical Association



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KMA INTERIM MEETING
April 8-9
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The girth control pill



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Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910

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(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

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Volume 68 • February 1970

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Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

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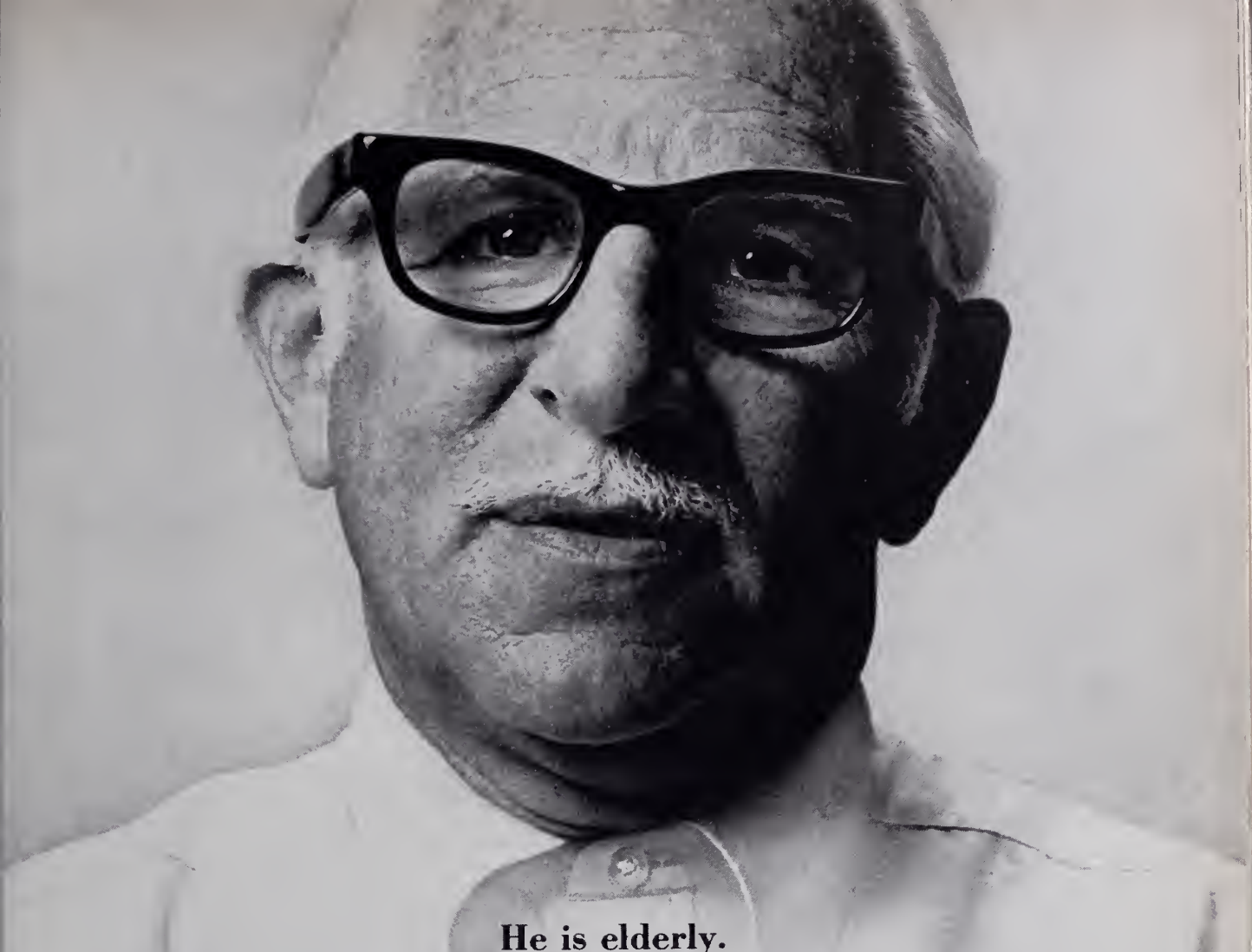
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He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

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Demethylchlortetracycline HCl 300 mg
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To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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345-B

MESSAGE FROM THE PRESIDENT



Charge — — Public Responsibility

SOON after his inauguration, President Eisenhower was shocked by the lack of concern by citizens in government. It is not possible for me to sufficiently emphasize the charge before you today. President Eisenhower called it, "An intelligent exercise of public responsibility."

Our government, which now pays almost 40 per cent of all health bills, grows ever more Orwellian. "It is enduring if not enchanting." Laws are continually passed. Many more are considered. Bills of medical interest brought before the recent 90th Congress numbered 1,435 and approximately 100 health bills are being proposed to the 1970 Kentucky Legislature. Even more rules and regulations are promulgated. It is not too late to show good citizenship even though much of the Legislative period has passed as you read this message.

Today, I charge you as physicians and members of the Kentucky Medical Association with its founding purpose of more than 120 years ago... "To serve the physician, the profession, and the public." The Kentucky Medical Association, never swerving from its original purpose, strives toward this goal today. These are trying times for medicine, society, our government, our churches, and for the world. The physician must make his voice heard. To do so effectively, expressions to our legislators must be on a basis of knowledge and understanding of all the facts.

Change is the most changeless fact of life. A. N. Whitehead has said, "The art of progress is to preserve order amid change and preserve change amid order." Please use your influence with the legislators for an organized approach on sound planning in an evolutionary manner rather than a radically revolutionary one. We can win if we understand Robert Frost when he said, "Something we were withholding made us weak until we found out it was ourselves." The shackling of our profession can occur only if there are enough weak physicians who do not assume public responsibility in the significant 70's.

Walter L. Cawood

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported, in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium and BUN during therapy, particularly in patients with suspected or confirmed renal or hepatic insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—their combined use can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk; thus adverse reactions which have occurred in adults may occur in the fetus or newborn infant. Rarely, thrombocytopenia or pancreatitis has developed in newborn infants whose mothers had received thiazides during pregnancy. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte determinations. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Adjust dose of antihypertensive agents given concomitantly.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, altered carbohydrate metabolism, hyperbilirubinemia, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories



Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm tially capsized. The fire departme had to rescue Waters by small bo Damage to the yacht is estimated

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

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Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



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Dear Doctor:

The 1969 Kentucky Medical Association House of Delegates reaffirmed support of the principle of payment of physicians' fees on a Usual and Customary basis. In accepting the report of the KMA Advisory Committee to Blue Shield, the House further clarified the Usual and Customary concept and provided a mechanism for Blue Shield to pay for covered services direct to the participating physician. In keeping with the wishes of the KMA House of Delegates, all physicians should have the opportunity to sign Participating Physician Agreements.

We plan to begin processing Usual and Customary claims using Participating Physician Agreements with claims received for services rendered on or after March 1, 1970.

Should you need additional agreements or have any questions about the Usual and Customary Program, please contact our Professional Relations Division, 3101 Bardstown Road, Louisville, Kentucky, 40205, phone: (502) 452-1511.

We appreciate your interest in Blue Shield.

Sincerely,

Garnett J. Sweeney M.D.

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IN THE BOOKS

MANUAL ON ARTIFICIAL ORGANS. VOLUME 1, THE ARTIFICIAL KIDNEY: by Yukihiko Nose, Ph.D.; Published by the C. V. Mosby Company, St. Louis, 1969; 343 Pages; Price $27.75.

In as rapidly moving a field as dialysis, there is a growing need for detailed technical manuals for nurses and technicians as well as physicians and patients. Prior to the publication of Dr. Nosé's book only manuals written for individual dialysis centers and manufacturers' technical manuals were available.

This manual is based on the extensive experience of the Cleveland Clinic with many types of dialysis equipment. The simple illustrations and the detailed methodology presented will be of assistance to the physician with no experience in hemodialysis, and to the patient and his family training for home hemodialysis.

The major failing of the manual is that it attempts to appeal to too wide an audience. However, a book intended for patient use, as the title suggests, should not include a chapter on patient selection nor material on medical complications. Conversely, the patient management aspects are oversimplified for use by the physician.

Some of the material presented is obsolete. Detailed presentation of the method of cleaning a Kiil dialyzer would have been a valuable addition. It may be that the lag between conception and publication has resulted in these flaws.

Figure 8-6 is incorrect, as it shows a peritoneal catheter pointed toward, rather than away from, the aortic bifurcation.

The practicing physician who may be asked to manage a home dialysis patient will find the manual very helpful. For the nephrologist, it is disappointing.

DANIEL E. LEB, M.D.

OPTHALMOLOGY: PRINCIPLES AND CONCEPTS; by Frank W. Newell ,M.D.; Published by the C. V. Mosby Company, St. Louis, 1969; 527 Pages; Price $15.50.

Ophthalmology: *Principles and Concepts,* is an excellent textbook by Frank Newell, M.D., professor and chairman of the department of ophthalmology at the University of Chicago.

The book is divided into four parts and includes a glossary and selected references. The glossary is particularly good since it covers completely the eye jargon which is so confusing to students and non-ophthalmologists. The selected references is a valuable addition, particularly to students and residents, since it gives many sources for additional information.

The parts of the book are divided into basic mechanisms, history taking and examination of the eye, diseases and injuries of the eye, and systemic diseases of the eye. Each part is then covered quite clearly and adequately along with numerous diagrams and pictures. There is minimal duplication of material which is sometimes difficult when one is covering systemic diseases involving all segments of the eye. Several sections have been shortened from the first editions, particularly, those on bacterial diseases. Many of these are now curiosities rather than common disorders and they have been deleted.

This book has been written to correlate diseases of the eye with anatomy, embryology, biochemistry, optics, pharmacology and other clinical courses. It is not meant to be used solely for undergraduate instruction.

Throughout the book, the author keeps the subject matter in proper perspective at all times. The reader never finds himself lost in a maze of minutiae. You are given the general principles rather than technical details. The reference list in the back gives the reader the opportunity to go into detail if he chooses.

This textbook can be strongly recommended for use by medical students and will also serve as a fine reference book for those in practice. The book is extremely well written and will pass the test of time.

JEREMIAH T. FLOWERS, M.D.

ATLAS OF HUMAN ELECTRON MICROSCOPY, by Ruben P. Laguens and Cesar L. A. Gomez Dumm; Published by The C. V. Mosby Company, St. Louis, 1969; 180 Pages; Price $20.50.

There is a critical need for an atlas of human ultrastructure aimed specifically at medical students, pathologists, and the general physician. The assembly and presentation of such an atlas represents a tremendously ambitious task for any single laboratory.

There are great difficulties inherent in obtaining specimens suitable for electron microscopy from biopsies and autopsies. It is this obstacle that has prevented this attempt by Doctors Laguens and Dumm from meeting more than the minimum level of acceptability. Perhaps of necessity, then, quality in microscopy has been sacrificed for quantity.

The low contrast of the micrographs throughout the atlas and the questionable fixation of many tissues are sometimes more misleading than helpful in the interpretation of structure. Concentration on individual tissues or cell types in atlases by other authors have produced more successful works. While the goal of the project as envisioned by the authors is to be commended, publication in this case is perhaps somewhat premature. Perhaps in the future, with improvements in this field, such an undertaking will meet with more success.

ROBERT L. SNIPES Ph.D.



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Quinamm™
(quinine sulfate 260 mg., ominophylline 195 mg.)

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0915A 1/70



Treating vaginitis is as easy as AVC

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You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfanamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfanamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfanamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystawsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Today's Drugs, New York, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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TRADEMARK: A V C

AV-919A 7/69

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 11-68. This 26-year-old married white gravida 4, para 3, had an expected delivery date of June 5, 1968. Prenatal care began the latter part of December 1967. She was seen at monthly intervals with no problems until May 14, when her blood pressure was found to be elevated. Hygroton 50 mg. daily with orange juice was prescribed.

The next office appointment was to be the 23rd of May. On the night of the 21st she called at 9 p.m. complaining of a severe headache and hospitalization was advised. Blood pressure on admission was 172/100. The fetal heart tones were normal. The cervix was 2 cm dilated, 60 per cent effaced. Pitting edema of the lower extremities was present. She received Morphine 10 mg. and Phenergan 25 mg. approximately 20 minutes after admission. A catheterized urine specimen revealed 3+ albumin.

Forty-five minutes later Thorazine 50 mg. was given and the patient seemed relatively quiet. One hour and ten minutes after admission, she cried out and was reported by the other patients in her room to be convulsing. Her blood pressure was 170/98, pulse 120; oxygen was given as well as Magnesium Sulphate 2 cc of a 50 per cent solution intramuscularly in each hip. She had three convulsions during the next hour and then none during the night. Blood pressure remained at levels of 160/98. The fetal heart tones remained normal. The next morning another physician was consulted. The consultant suggested induction of labor by artificial rupture of the membranes and administration of oxytocin.

At 10 a.m. the membranes were punctured. The cervix was three cm dilated. Labor progressed and she received one buccal oxytocin tablet at 11:30 a.m. A spinal anesthetic was given using Tetracaine and at 11:59 a.m. she delivered spontaneously a six pound four ounce girl. Blood pressure in the delivery room was 140/90. She was alert and cooperative. The midline episiotomy was repaired. Blood pressure at 1 p.m. was 200/100. She complained of a headache and at 1:25 p.m. the nurses reported profuse vaginal bleeding. The uterus was found to be atonic, intravenous infusion of 1,000 cc five per cent Dextrose and water with 30 units of oxytocin was started. Several clots were expressed from the uterus. Blood pressure fell to 110/50 and at 1:45 p.m. was found to be 90/20. Blood was ordered but obtained with difficulty from an adjacent city as there was a problem in crossmatching.

The first pint of blood was started at 3:30 p.m. and the second at 3:55. Blood pressure was 80/44 and was maintained at this level for approximately one hour. The pulse was weak and thready. The uterus remained atonic. It was estimated that she lost approximately 1,000 cc of blood during the two hour period before the blood arrived.

Following the blood replacement, 1,000 cc of Normosol® was given with 30 units oxytocin at a slow rate. Lacerations of the tongue produced a small amount of bleeding that required frequent suction. Legs were wrapped with elastic bandages and she was maintained in a deep Trendelenberg position. Her condition continued to deteriorate. Another consultation was obtained. Urinary output following delivery was only 100 cc, fluid intake was restricted. At 10:30 a.m. the following day her respirations became quite shallow and her blood pressure was unobtainable. Mouth to mouth resuscitation, three shocks were administered to the chest wall, however, no heart beat could be restored. Her pupils were noted dilated and no further resuscitative efforts were attempted.

An autopsy was obtained. An extensive subarachnoid hemorrhage apparently arising at the vertex over the right cerebral hemisphere was found. Examination of the vaginal vault revealed no lacerations or obvious hemorrhage. The cervic was intact. The uterus was intact.

(Continued on Page 76)

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Comment

The Committee classified this as a direct obstetrical death with preventable factors. It was considered that the patient was inadequately treated for toxemia of pregnancy. Although the initial blood pressure elevation was not reported it is conceivable that she might have required hospitalization at that time. Following the development of Eclampsia, therapy was not sufficiently vigorous and the administration of multiple drugs in small dosages is to be deplored. The patient's condition apparently was not sufficiently stabilized prior to delivery.

Measures to control uterine atony were insufficient and blood replacement was inadequate to control hemorrhagic shock. The choice of Dextrose solution for intravenous fluid therapy in the presence of active bleeding and shock was criticized. In addition, fluid replacement was deficient in amount and the Committee considered the restriction of fluid intake inappropriate in view of the reduced circulating blood volume.

In the opinion of the Committee the neurological problem might have been prevented by a greater effort to control the hypertension and by restoring circulating blood volume to alleviate shock.

It is possible that a coagulation disorder was present that caused the cerebral bleeding.

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PLAN TO ATTEND

Sixteenth Annual Symposium on Cardiovascular Diseases

March 25 and 26, 1970

STOUFFER'S LOUISVILLE INN — LOUISVILLE, KENTUCKY

Wednesday, March 25, 1970
9:00 a.m.

"Cardiac Pacemakers"

ROBERT C. SCHLANT, M.D., Professor of Medicine, Coordinator, Division of Cardiology, Emory University School of Medicine, Atlanta, Georgia

"Surgical Treatment in Bacterial Endocarditis"

E. L. QUINN, M.D., Chairman, Division of Infectious Diseases, Department of Medicine, Henry Ford Hospital, Detroit, Michigan

"Pulmonary Embolism"

T. J. FOGARTY, M.D., Division of Cardiovascular Surgery, Stanford University Medical School, Stanford, California.

"Pathophysiology of Coronary Atherosclerotic Heart Disease"

ROBERT C. SCHLANT, M.D.

"RENAL VASCULAR SEMINAR"

"The Kidney and Hypertension"

LOUIS J. TOBIAN, M.D., Professor of Medicine, University of Minnesota School of Medicine, Minneapolis, Minnesota

"The Role of the Kidney in Congestive Heart Failure"

JOHN P. MERRILL, M.D., Associate Professor of Medicine, Harvard Medical School, Boston, Massachusetts

"The Treatment of Edema"

DONALD E. OKEN, M.D., Associate Director, Cardiorenal Section, Peter Bent Brigham Hospital and Assistant Professor, Harvard Medical School, Boston, Massachusetts

PANEL DISCUSSION

Thursday, March 26, 1970
8:30 - 9:30 a.m.

"Grand Rounds"

Louisville General Hospital, Rankin Amphitheatre, BEVERLY T. TOWERY, M.D., Conducting Lecturer: NOBLE O. FOWLER, M.D.

10:00 a.m.
STOUFFER'S LOUISVILLE INN

"Clues for Unraveling the Hypertension Problem"

LOUIS J. TOBIAN, M.D.

"Peripheral Venous or Arterial Thrombosis"

T. J. FOGARTY, M.D.

"Neurovascular Diagnosis with Radiopharmaceuticals"

RICHARD JANEWAY, M.D., Acting Chairman, Department of Neurology, Bowman Gray School of Medicine, Winston-Salem, North Carolina

THE BERNARD D. ROSENBLUM MEMORIAL LECTURE

"Pericardial Disease"

NOBLE O. FOWLER, M.D., Professor of Medicine, Cardiac Research Laboratory, Cincinnati General Hospital, Cincinnati, Ohio

"Methods for Determining Choice of Treatment in Cerebral Vascular Disorders"

RICHARD JANEWAY, M.D.

"Antibiotic Treatment of Bacterial Endocarditis"

E. L. QUINN, M.D.

PANEL DISCUSSION

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THE HEART ASSOCIATION OF LOUISVILLE AND JEFFERSON COUNTY, INC., THE UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE AND THE JEFFERSON COUNTY ACADEMY OF GENERAL PRACTICE and co-sponsored by THE COUNCIL ON CLINICAL CARDIOLOGY, AND THE COUNCIL ON CIRCULATION, RENAL SECTION, AMERICAN HEART ASSOCIATION.

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ANSWERS TO YOUR QUESTIONS ABOUT BLUE SHIELD

The Extended Benefits Endorsement

Q. What is the Extended Benefits Endorsement?

A. The Extended Benefits Endorsement extends and supplements the hospital, surgical and medical benefits as outlined in the basic Blue Cross and Blue Shield Certificates of Membership during a "benefit period."

Q. What begins and ends a benefit period under the Extended Benefits Endorsement?

A. A "benefit period" under this Endorsement begins on the first day on which a member receives any benefits under the basic Certificate of Membership and/or this Endorsement and extends for a period of 730 days. A "benefit period" ends when 730 consecutive calendar days have elapsed; or when, for nervous and mental disorders and pulmonary tuberculosis, 120 calendar days of in-patient care have elapsed; or when 180 consecutive calendar days have elapsed during which time no services of the type covered by the basic Certificate of Membership or the Extended Benefits Endorsement are used by the member. A "benefit period" also ends when $20,000.00 has been paid under this Endorsement.

Q. Does the Extended Benefits Endorsement increase the member's coverage for out-of-hospital services?

A. Yes. After a $25.00 deductible for each illness or injury, a member is entitled to 80 per cent of the charges in excess of the benefits provided under his basic Certificates of Membership or endorsement for: X-ray examinations; laboratory examinations; physical therapy; X-ray and radiation therapy; and EKG's. In addition, a member is entitled to physician services for acute psychotic reactions as follows: Insulin shock therapy; $5.00 per sub coma treatment, $8.00 per coma treatment, limited to 70 treatments; Electric Shock therapy, $12.00 per treatment, limited to 20 treatments; Anesthesia in connection with shock treatments when performed by a physician other than the attending physician, $10.00 per treatment. These services are covered in the out-patient department of a hospital, doctor's office, or laboratory when prescribed by the attending physician.

Q. What additional benefits are available under the Extended Benefits Endorsement following hospitalization?

A. Following hospitalization, 80 per cent of the Usual and Customary Charge for prescription drugs; 80 per cent of the charges for the rental or purchase of surgical and orthopedic appliances and $3.00 per visit for the services of a Visiting Nurse, not to exceed one visit per day, are covered when rendered at the direction of the attending physician. If a member is admitted to an approved nursing home within 72 hours after discharge from a hospital, an allowance of $12.00 per day will be provided for this care. To be covered, these services must be related to the condition for which the member was hospitalized.

Q. Does the Extended Benefits Endorsement include coverage for home and office visits?

A. Yes. Following a non-surgical hospital admission and during a benefit period, the Extended Benefits Endorsement will make indemnity allowances of $6.00 per physician's home visit or $5.00 per physician's office visit when prescribed for the condition which required the hospitalization. This provision is limited to one visit per day.

Q. How may Blue Cross and Blue Shield members having the Extended Benefits Endorsement be identified?

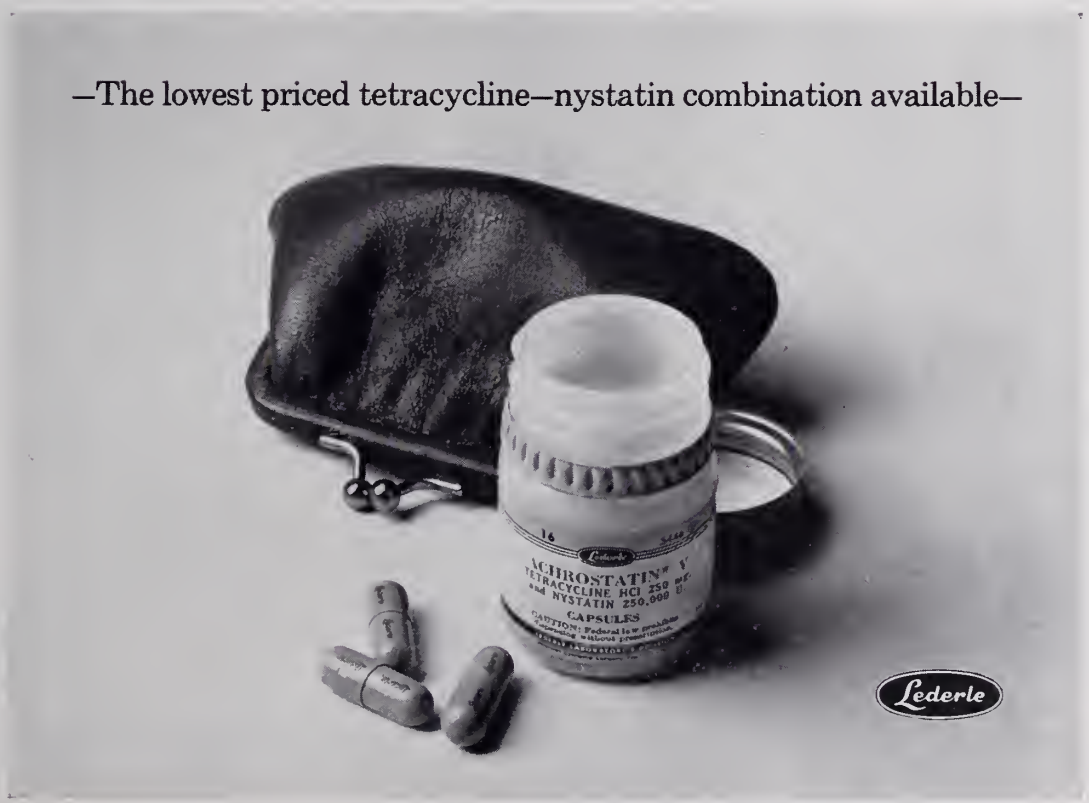
A. Members having this Endorsement may be identified by referring to the "Other Coverage" section of the Blue Cross and Blue Shield Identification Card. The digits, "50," in this position on the card indicate the subscriber has the Extended Benefits Endorsement on a single basis covering only the person whose name appears on the Card. A "60" in this position means that the subscriber has Extended Benefits on a family basis covering himself and his eligible dependents.

Q. How are claims filed?

A. For extended hospital expenses, surgery, or physicians in-hospital calls, no additional claim form is required. Claims for both the basic Blue Cross and Blue Shield and Extended Benefits will be processed when the Blue Cross or Blue Shield claim form is filed. The other covered services under the Endorsement are to be reported on the Extended Benefits claim form to be completed by the member and signed by the physician.

Q. Who is eligible to apply for the Extended Benefits Endorsement?

A. The Extended Benefits Endorsement is available to employer groups of five or more, and to non-group subscribers, having Comprehensive Blue Cross and indemnity Blue Shield. As of November, 1969, approximately 186,000 Blue Cross and Blue Shield members were covered by this Endorsement.



Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT SECTION

1970 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 22, 23, 24**

Fill Out and Mail to:

T. R. MARSHALL, M.D., Chairman

Committee on Scientific Exhibits

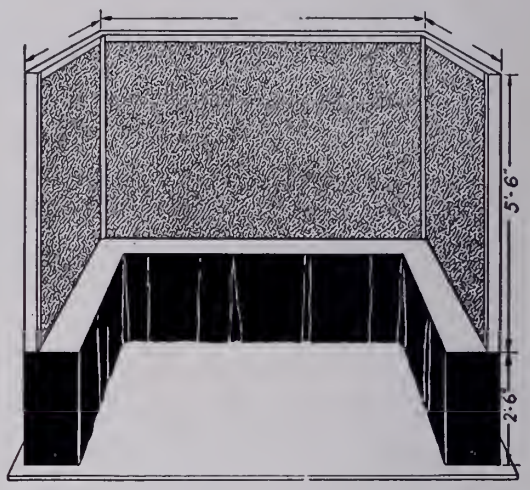
Kentucky Medical Association

3532 Ephraim McDowell Drive

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1970

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....
   Institution (if desired): .....
   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)
   Charts and Posters.... Photographs.... Drawings.... X-rays ....
   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
   Amount of total wall space needed? .....
   Back wall ..... Side walls (All side walls are 4') .....
   Square feet needed? ..... Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided to you in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

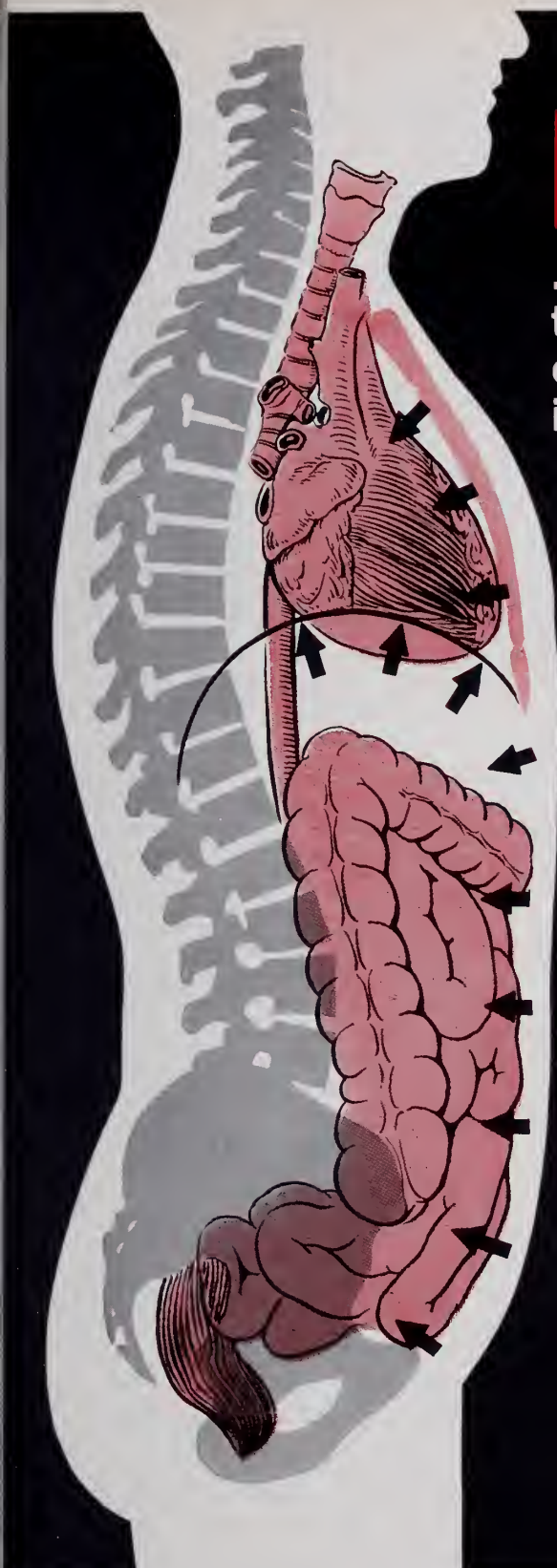
Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

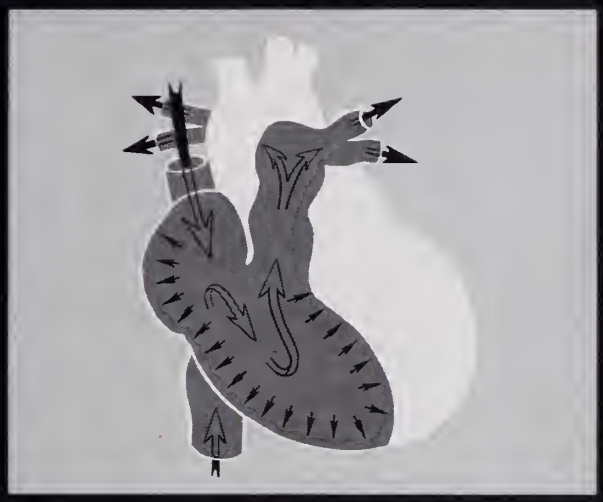
Due to the shortage of space, please have your exhibit as compact as possible.



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Constipation in the chronic heart failure patient carries with it the ever-present threat of acute cardiac decompensation while straining at stool. In the already weakened, distended heart, a sudden influx of blood on termination of the Valsalva maneuver is considered to be the mechanism of some of the deaths occurring in these cardiac patients during straining efforts.*



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Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice,* 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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FEBRUARY

11 PANMED television series, "Drug Interaction —II," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

16 PANMED television series, "Drug Interaction —II," in Louisville, WKPC-TV 10 p.m.

18 PANMED television series, "Eye of the Beholder," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

23 PANMED television series, "Eye of the Beholder," in Louisville, WKPC-TV 10 p.m.

25 PANMED television series, "Commonly Occurring Cardiac Arrythmias," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

MARCH

2 PANMED television series, "Commonly Occurring Cardiac Arrythmias," in Louisville, WKPC-TV 10 p.m.

4 PANMED television series, "Gingivectomy—An Obsolete Procedure?" KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

9 PANMED television series, "Gingivectomy—An Obsolete Procedure?" in Louisville, WKPC-TV 10 p.m.

11 PANMED television series, "Formulation and Drug Availability," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

16 PANMED television series, "Formulation and Drug Availability," in Louisville, WKPC-TV 10 p.m.

18-20 Postgraduate course, "The Head of the Child," University of Kentucky Medical Center, Lexington.

18 PANMED television series, "Patterns of Nursing I," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

23 PANMED television series, "Patterns of Nursing—I," in Louisville, WKPC-TV 10 p.m.

25-26 "Symposium on Cardiovascular Disease," sponsored by the Heart Association of Louisville and Jefferson County, Stouffer's Louisville Inn.

25 PANMED television series, "Preparation of the Child for the Hospital," KETV-TV 10:00 p.m. EST (9:00 p.m. CST)

30 PANMED television series, "Preparation of the Child for the Hospital," in Louisville, WKPC-TV 10 p.m.

APRIL

2 Fifteenth Annual Spring Clinical Conference, Lexington Clinic, "Diabetes Mellitus-1970," Lexington

7 KMA Senior Day Program, Continental Inn, Lexington

8-9 KMA INTERIM MEETING, "Kentucky Medicine in the 70's," Kentucky Dam Village State Park, Gilbertsvile

IN SURROUNDING STATES

FEBRUARY

25-March 1 American College of Cardiology, 19th Annual Scientific Session, New Orleans, La.

8-9 Annual Congress on Medical Education, Palmer House, Chicago, Ill.

MARCH

11-12 Postgraduate course, "Current Management of Common Orthopedic Problems," Cleveland Clinic Educational Foundation, Cleveland

20-21 Fourth National Congress on the Socio-Economics of Health Care, Palmer House, Chicago, Ill.

APRIL

9-10 National Conference on Rural Health, sponsored by AMA's Council on Rural Health, Pfister Hotel & Tower, Milwaukee

18-19 Freedman Lectures in Diagnostic Radiology, University of Cincinnati College of Medicine

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Contraindications: Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma-

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prompt anti-inflammatory effectiveness
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usual dosage: 1 capsule q.i.d. initially, then 1 or 2 daily

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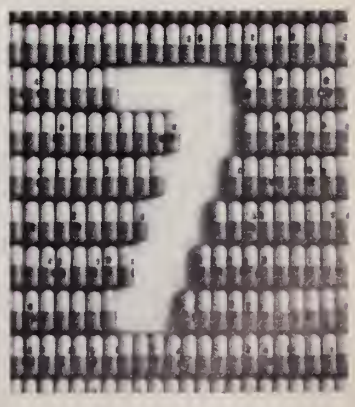
Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings and contraindications. Read the prescribing information. It's summarized below.

is, Stevens-Johnson syndrome, ell's syndrome (toxic necrotizing idermolysis), or a generalized ergic reaction similar to serum ckness may occur and require rmanent withdrawal of medica- n. Agranulocytosis can occur ddenly in spite of regular, repeated rmal white counts. Stomatitis d, rarely, salivary gland enlarge- ent may require cessation of treat- ent. Such patients should not ceive subsequent courses of the ug. Vomiting, vertigo and languor ay occur. Leukemia and leukemoid actions have been reported. While t definitely attributable to the ug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily. In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-C

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but they are often a clear indication for

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effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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WHAT'S NEW

in

Medical Progress

Current Status of Angiography

William R. Merritt, Jr., M.D.*

Angiography has greatly improved diagnostic acumen in the past two decades. Some of its more frequent uses and limitations are detailed.

There has been a striking increase in angiographic examinations during recent years. The increase has been occasioned by availability of less toxic contrast media[1], more sophisticated radiographic equipment, the Seldinger technique for percutaneous introduction of catheters[2], and new and improved surgical procedures. Although there have been equal advances in cerebral and cardiovascular studies, the purpose of this report is to review the current status of other applications of angiography.

Technique

Catheterization of vessels utilizing the Seldinger technique involves the insertion of a catheter over a guide wire introduced through a percutaneously inserted needle. Placement of the catheter is monitored constantly by image intensified fluoroscopy or television. Maneuvering the catheter into major branches of the aorta (selective catheterization) and into second order branches of these vessels (superselective catheterization) overcomes the disadvantage of superimposition of multiple vessels, a problem encountered with injections into the aorta. Sequential films are exposed on a rapid serial film changer.

Contraindications and Complications

The one absolute contraindication to angiography is a previous severe reaction to a contrast medium. Anuria, low cardiac output, allergy to iodinated contrast media, hemorrhagic diathesis, and absence of the pulse distal to the proposed puncture site are all relative contraindications to be weighed in the light of the importance of information to be gained. Complications secondary to contrast media are less frequent subsequent to the introduction of the diatrizoates and methylglucamines. Thrombus formation at the site of puncture, however, remains a possible complication of considerable consequence. Axillary artery puncture may be associated with neurological deficits secondary to bleeding into the neurovascular sheath, pneumothorax or compromise of the ipsilateral vertebral artery.

Renal Angiography

Surgically remediable lesions that lead to renal ischemia and secondary hypertension have given marked impetus to aortography and selective renal arteriography. In the assessment of a hypertensive patient, aortography to locate orifices of the renal arteries should precede selective renal arteriography. Aortography is less likely to cause renal artery spasm which can simulate organic disease[3, 4]. The hemo-

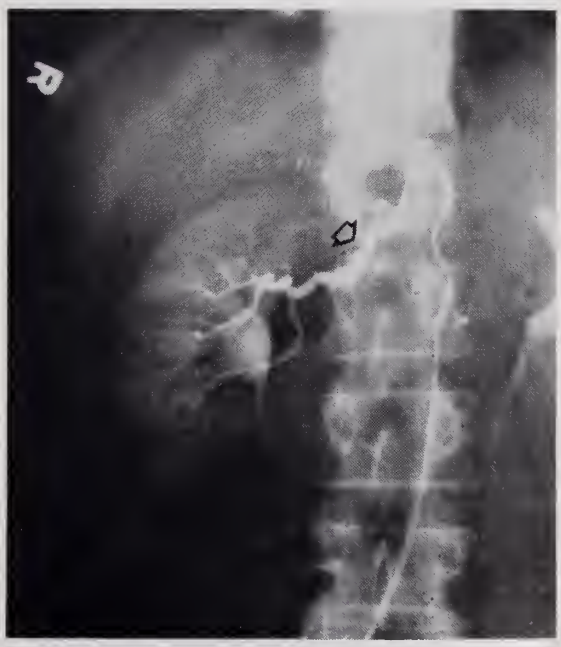


FIG. 1 Fibromuscular dysplasia (medial type) of the right renal artery.

Assistant professor, Department of Diagnostic Radiology, University of Kentucky Medical Center, Lexington.

dynamic significance of renal artery narrowing best correlates with the magnitude of the pressure gradient across the stenotic area and with the presence of collateral circulation bypassing the obstruction. The most frequent cause of renal artery stenosis is an atheromatous plaque which usually is eccentric and localized to the proximal portion of the renal artery. Fibromuscular dysplasia (Fig. 1) of the renal arteries is another process which may cause renovascular hypertension [6, 7]. It is usually manifested as an alternating series of stenoses and dilatations presenting a "string of beads" appearance.

Intrarenal arteriovenous fistulas may shunt blood from portions of the renal parenchyma causing segmental ischemia and secondary hypertension [8, 9]. Renal artery aneurysms (Fig. 2) also may produce hypertension by an unknown mechanism [10, 11]. Both of these lesions are readily diagnosed by angiography.



FIG. 2 Intrarenal renal artery aneurysm.

Selective renal arteriography is valuable in the differential diagnosis of renal mass lesions [12, 13]. A benign cyst appears as a sharply defined, thin-walled avascular mass that displaces normal blood vessels. A "spur" of normal renal cortex at the edge of the lesion is particularly helpful. This appearance is not pathognomonic and may be seen in fibromas, lipomas and other masses lacking a good blood supply [14]. The parapelvic cyst is a more difficult diagnosis in that wall thickness and "spur" formation is obscured. It may be indistinguishable from a cystic or necrotic hypernephroma. Most renal cell carcinomas display abundant abnormal tumor vessels (Fig. 3) ,or a tumor stain. There often is early visualization of a renal vein from shunting of the contrast agent through small arteriovenous-venous communications in the tumor. Although occasionally a malignancy is relatively avascular or necrotic, there usually is a thick wall which displays abnormal tumor circulation [15]. Processes such as renal hamartomas [16, 17],



FIG. 3 Hypernephroma superior pole, right kidney.

renal abscess [17] and other inflammatory processes may have abnormal vessels which are virtually indistinguishable from tumor vessels [18, 19].

Renal angiography demonstrates numerous small aneurysms throughout the kidney as a pathognomonic finding of pertiarteritis nodosa. The evaluation of renal trauma, renal artery embolus [20, 21], vascular nephralgia [22] and renal vein thrombosis are also aided by angiography.

Because the feasibility of renal transplantation is determined by the number and size of the renal arteries as well as their condition, aortography is mandatory in donor selection. Subsequent to grafting, the rejection phenomenon correlates well with slow flow of contrast material, edema, sparse arborization and narrowing of peripheral vessels.

Hepatic Angiography

Hepatic arteriography plays a useful role in the diagnostic evaluation of suspected neoplasia. This is true because a majority of liver tumors derive their blood supply from the hepatic artery rather than the portal system. Both primary and metastatic tumors in the liver usually are richly vascular and can be identified on angiograms by the presence of a tumor stain or by macroscopic collections of neovascularity. Vascular malformations, aneurysms, arteriovenous fistulas, hemangiomas, cysts, abscesses and hepatic trauma are accurately demonstrated by angiography. The liver is best studied by selective injection of the contrast agent directly into the hepatic artery.

Adrenal Angiography

Since the adrenals have multiple feeding arteries, venography has emerged as the angiographic examination of choice in the assessment of the adrenal glands. Not only can tumors be identified, but samples of venous blood also can be collected for hormonal assay. It is particularly important when a pheochromocytoma is suspected to have phentolamine

(Regitine*) available at the time of angiography to counteract the consequences of a hypertensive crisis that may be provoked.

Portography

An evaluation of portal hypertension is the main indication for this study. Visualization of the portal veins is best accomplished by delayed post-epinephrine celiac and mesenteric arteriography [25, 27]. This procedure is rapidly displacing direct percutaneous injection of contrast material into the splenic substance. The goal is to determine whether the portal vein and its tributaries are patent, to demonstrate sites of occlusion if they are present, and to opacify the routes of collateral flow. It has been shown recently that varices often are much more widespread, even involving the duodenum, than was previously realized.

Pancreatic Angiography

Pancreatic angiography has not gained wide acceptance because of the relatively avascular nature of most pancreatic neoplasms as well as the multiple arteries supplying the pancreas. Most of the changes reported to accompany carcinoma of the pancreas or pancreatitis are subtle and not seen with dependable frequency. On the other hand, angiomas, cystadenomas, and cystadenocarcinomas and particularly islet cell tumors are well seen at angiography since they are highly vascular [26].

Abdominal Angiography

Angiography of the bowel makes its greatest impact in the demonstration of obstructive vascular lesions



FIG. 4 Collateral flow from the inferior mesenteric to the superior mesenteric artery.

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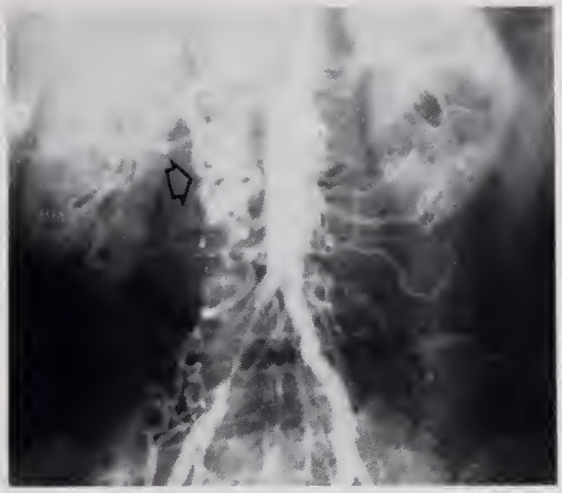


FIG. 5 Collateral flow from the superior mesenteric artery to the celiac axis.

potentially capable of causing ischemic bowel disease. The secondary collateral circulation that develops secondary to these stenotic areas (Figs. 4 & 5) is vividly seen. It has been stated that two of the three major abdominal arteries or two-thirds of the cross sectional area of these branches must be occluded in order for symptoms of bowel ischemia to occur [27]. Aneurysms, arteriovenous malformations, fistulas, and certain vascular tumors also may be seen. Angiographic studies may be of great value in identifying the site of active gastrointestinal bleeding that eludes other methods of study.

Peripheral Angiography

Aortography and phlebography of the extremities as well as of the aortoiliac vessels is of greatest benefit in demonstrating the sites and extent of occlusive vascular disease. Collateral vessels are easily seen. Incompetent venous values are easily shown by peripheral phlebography. Vascular abnormalities and well vascularized neoplasms of the extremities are revealed by arteriography. An interesting by-product of work in this region is the percutaneous transluminal treatment of arteriosclerotic obstruction [28].

Lymphangiography

Bilateral lower extremity lymphangiography yields diagnostic information concerning patency and number of the lymph channels in the legs. The status of the inguinal, iliac, and periaortic nodes can be assessed. This examination has proved to be of greatest benefit in the staging of lymphomas and in judging the efficacy of chemotherapy and/or radiation therapy of these tumors. Lymphomatous nodes are characteristically enlarged and present a foamy appearance (Fig. 6). Metastatic disease leads to defects in the visualized nodes or, indeed, nonvisualization when the nodes are totally replaced with neoplastic tissue. Lymphangiography also offers information of value in congenital lymphatic abnormalities,



FIG. 6 Lymphoma involving iliac and periaortic nodes.

primary and secondary lymphedema, chyluria and chylous effusions. Lymphangiography is contraindicated in patients with severely compromised pulmonary function because of the inevitable small oil emboli to the lungs that accompany this examination, particularly if large quantities of contrast material are injected too rapidly. The difficulty encountered in isolating small lymphatic channels and the time consumed in the study are the major deterrents to a more general use of this type of examination.

References

1. Killen, D. A. and Foster, J. H. Spinal Cord Injury as a Complication of Contrast Angiography. *Surgery* 59: 969-981, 1966.
2. Seldinger, S. I. Catheter Replacement of Needle in Percutaneous Arteriography: New Technique. *Acta Radiol.* 39: 368-376, 1953.
3. Koehler, P. R., and Friedenberg, M. J. Renal Artery Spasm Simulating Organic Disease. *Am. J. Roentgenol.* 95: 318-322, 1965.
4. Meaney, J. F. and Buonocore, E. Contractions of Renal Arteries During Arteriography. *Radiology* 86: 41-48, 1966.
5. Bookstein, J. J. Appraisal of Arteriography in Estimating Hemodynamic Significance of Renal Artery Stenosis. *Investigative Radiology* 1: 281-294, 1966.
6. Palubinskas, A. J. and Wylie, E. J. Roentgen Diagnosis of Fibromuscular Hyperplasia of Renal Arteries. *Radiology* 76: 634-639, 1961.
7. Hunt, J. C., Harrison, E. G., Jr., Kincaid, O. W. Bernatz, P. E., and Davis, G. D. Idiopathic Fibrous and Fibromuscular Stenosis of Renal Arteries Associated with Hypertension. *Proc. Staff Meet. Mayo Clin.* 37: 181-216, 1962.
8. Boijsen, D. and Kohler, R. Renal Arteriovenous Fistulae. *Acta Radiol.* 57: 433-445, 1962.
9. Love, L., Moncada, R. and Lescher, A. J. Renal Arteriovenous Fistulae. *Am. J. Roentgenol.* 95: 364-371, 1965.
10. Boijsen, E. and Kohler, R. Renal Artery Aneurysms. *Acta Radiol. (Diagn.)* 1: 1077-1090, 1963.
11. *Renal Angiography.* Edited by O. W. Kincaid and G. D. Davis. Chicago, Yearbook Medical Publishers, 1966.
12. Folin, J. Angiography in Renal Tumors: Its Value in Diagnosis and Differential Diagnosis as Complement to Conventional Methods. *Acta Radiol. (Diagn.) Suppl.* 267: 7-96, 1967.
13. Halpern, M. Renal-Cell Carcinoma. *New Eng. J. Med.* 270: 108, 1964.
14. Melicow, N. M. and Becker, J. A. Radiologic Simulation of Certain Solid Tumors of Renal Corpus to Renal Cyst. *J. Urol.* 97: 592-610, 1967.
15. Ronniger, K. Selective Renal Arteriographic Appearance of Necrotic Hypernephroma. *Radiology* 83: 414-418, 1964.
16. Love, L. and Frank, S. J. Angiographic Features of Angiomyolioma of Kidney. *Am. J. Roentgenol.* 95: 406-408, 1965.
17. Viamonte, J., Jr., Ravel, R., Politano, V., and Bridges, B. Angiographic Finding in Patients with Tuberous Sclerosis. *Am. J. Roentgenol.* 98: 723-733, 1966.
18. Caplan, L. H., Siegelman, S. S., and Bosniak, M. A. Angiography in Inflammatory Space-Occupying Lesions of Kidney. *Radiology* 88: 14-23, 1967.
19. Salmon, R. B. and Koehler, P. R. Angiography in Renal and Perirenal Inflammatory Masses: Report of Three Cases. *Radiology* 88: 9-13, 1967.
20. Heitzman, E. R. and Perchik, L. Radiographic Features of Renal Infarction: Review of 13 Cases. *Radiology* 76: 39-46, 1961.
21. Siegelman, S. S. and Caplan, L. H. Acute Segmental Renal Artery Embolism: Distinctive Urographic and Arteriographic Complex. *Radiology* 88: 509-512, 1967.
22. Nebesar, R. A., Pollard, J. J., and Fraley, E. E. Renal Vascular Impressions: Incidence and Clinical Significance. *Am. J. Roentgenol.* 101: 714-727, 1967.
23. Breedis, C. and Young, G. Blood Supply of Neoplasms in Liver. *Federation Proc.* 8: 351, 1949.
24. Nebesar, R. A., Pollard, J. J., and Stone, D. L. Angiographic Diagnosis of Malignant Disease of Liver. *Radiology* 86: 284-292, 1966.
25. Kahn, P. C., Halloran, J. F., and Paul, R. E. Improved Portography by Delayed Postepinephrine Celiac and Mesenteric Arteriography. *Radiology* 92: 86-89, 1969.
26. Olsson, O. Angiographic Diagnosis of Islet Cell Tumor of Pancreas. *Acta. Chir. Scandinav.* 136: 346-351, 1963.
27. Dick, A., Graff, R., Gregg, D., Peters, N., and Sarner, M. An Arteriographic Study of Mesenteric Arterial Disease. *Gut* 8: 206-220, 1967.
28. Dotter, C. T., and Judkin, M. Percutaneous Transluminal Treatment of Arteriosclerotic Obstruction. *Radiology* 84: 631-643, 1965.



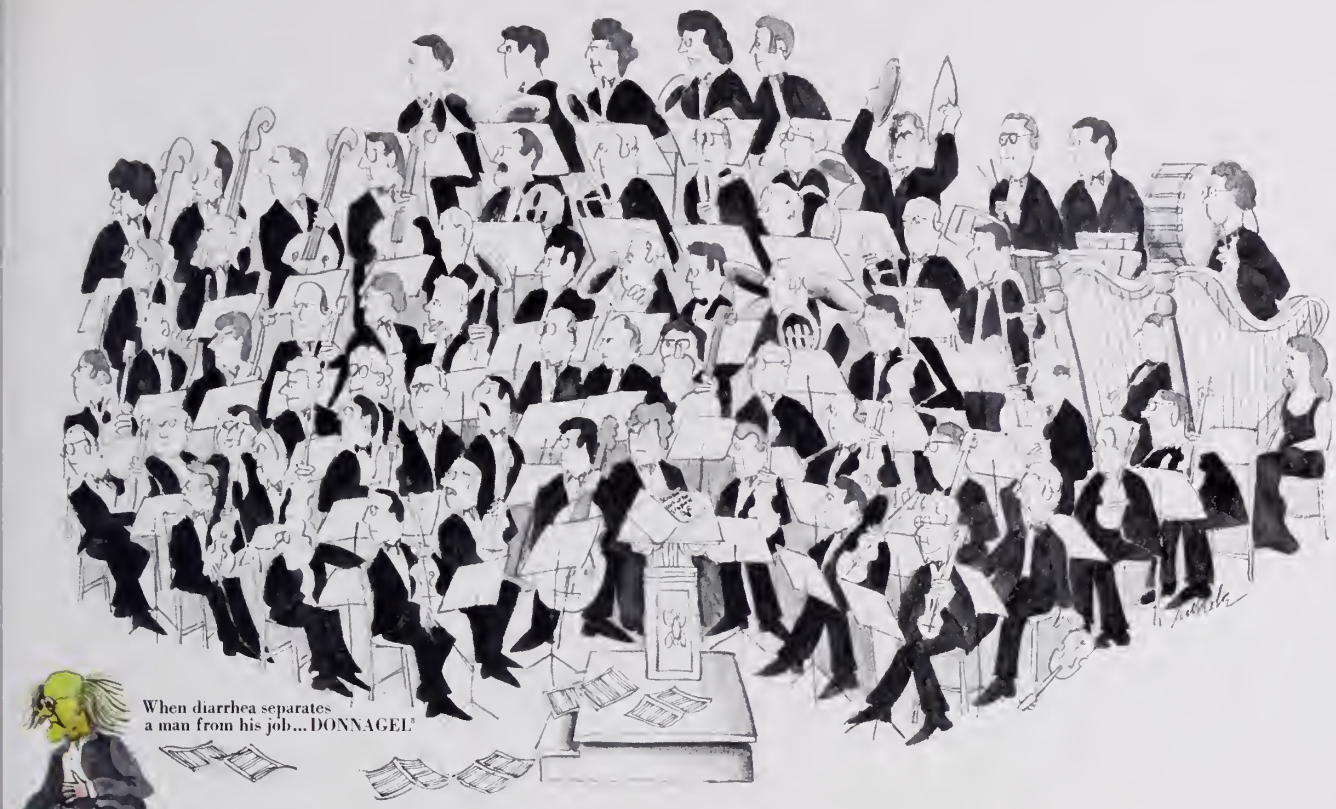
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Our theme in the Auxiliary this first year of the spectacular 70's has been "Get Involved."

The early months of 1970 finds many Auxiliary members are doing just that. They are busy in activities that are particularly significant to husbands and wives of the medical profession. "Kentucky Legislation 1970" and "Stopping Rubella."

With both ours' and our husbands' futures being formulated in the halls and chambers of the legislature in Frankfort, we of the Auxiliary are urged to participate in this activity. In current history, any state legislature will be either greatly contributory or condemnatory to medicine and its practitioners and patients.

"Ladies Day in Frankfort" is a program geared to inform, instruct and educate physicians' wives in the whys, hows and wherefores of state government and what is the effective way to assist, preserve and improve the high standards and ideals of medicine and thus, to reassure the public expectancy.

All 1,350 Auxiliary members have been invited and encouraged to attend this program.

On December 16, Governor Louie B. Nunn announced in a seminar a statewide program to "Stop Rubella." Auxiliary members from various areas of the state attended that seminar. We are now orienting our own members and are hopeful that these knowledgeable Auxiliarians will assist local communities in the importance of the prevention of Rubella and its dual consequences. The film "Stop Rubella" is available to Auxiliaries throughout the state and, with the private physician and the state and county health departments working hand in hand, all children under age 12 will receive this vaccine.

We of the Auxiliary are delighted to have this opportunity to relate to you the activities of the Auxiliary.

For any comments or suggestions please contact us—Don't be surprised if we contact you. Join with us by "Being Involved."

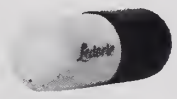
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VOLUME 68 February 1970 No. 2

Coal Workers' Pneumoconiosis†

GRADIE R. ROWNTREE, M.D., M.P.H.*

Frankfort, Kentucky

Pneumoconiosis is a major problem in the coal industry and the most serious illness hazard to coal workers. The health and safety of coal miners is of first importance in the continuation of coal production in Kentucky.

LEGISLATIVE proposals are now before the United States House and Senate for a comprehensive new program to advance the health and safety of workers in coal mines. The bills would provide for research on the prevention and control of coal workers' pneumoconiosis, improvement of Workmens' Compensation programs in the states, and study of measures for reducing mine accidents.

Since this article was submitted for publication, the President of the United States has signed into law the Coal Mine Health and Safety Act 91-173.

As early as 1937, the British Medical Research Council began a comprehensive study of chronic chest diseases affecting coal miners. A report issued in Great Britain in 1942 recognized coal workers' pneumoconiosis as a disease entity separate from silicosis. In 1943, coal workers' pneumoconiosis became compensable in Great Britain.

In the United States, it was not generally recognized as a separate disease until 1959. While the U. S. Public Health Service and the Bureau of Mines made cooperative studies on miners' health problems for 30 years, it was not until 1963 that the PHS received funds for a study of the prevalence of coal workers' pneumoconiosis in the United States.

The British Medical Research Council, in 1945, established a research unit on pneumoconiosis which has resulted in better diagnosis, control and prevention of the disease. They report that there has been an 80 per cent reduction in the number of new cases of coal workers' pneumoconiosis diagnosed each year since 1949.

Coal workers' pneumoconiosis is a chronic lung disease caused by the accumulation of coal dust in the lung, inhaled in heavy concentration over a long period of time. It can be detected in life only by means of the chest x-ray and an occupational history. In 1958, the International Labor Office recommended the classification of coal workers' pneumoconiosis into two major categories: simple pneumoconiosis and complicated pneumoconiosis. Simple pneumoconiosis causes little respiratory impairment. Complicated pneumoconiosis causes severe dis-

†*Presented at the annual meeting of the Kentucky Mining Institute, November 21, 1969, Lexington*

**Consultant to the State Commissioner of Health on Occupational Health, Department of Health, Frankfort*

ability and frequently results in death from heart failure, asphyxia or pneumonia. On the chest x-ray, in simple pneumoconiosis, the dust particles begin to localize and signs of emphysema appear. In complicated pneumoconiosis, the lungs show massive fibrosis and emphysema and lung destruction becomes widespread.

The diagnosis of coal workers' pneumoconiosis involves a history of exposure to coal dust, x-ray changes indicating the presence of the disease, pulmonary function changes and a history of symptoms of the disease such as shortness of breath, difficulty in breathing, coughing, and wheezing.

Coal workers' pneumoconiosis is a progressive disease. The progression of simple pneumoconiosis depends on the concentration of dust in the air breathed and the duration of exposure.

Simple pneumoconiosis rarely progresses in the absence of further dust exposure, that is, if the worker is removed from exposure or transfers to a less dusty environment. However, if simple pneumoconiosis has become complicated by the development of progressive massive fibrosis it may progress whether the worker continues to be exposed to coal dust or not.

The length of time it takes for the progression of simple pneumoconiosis to the complicated type with its resulting disability varies considerably. No definite standard can be set for the date of last exposure and onset of disability.

It generally requires an average of 15 years of underground exposure for the development of pneumoconiosis. In the 1964 prevalence survey, it was found that the number of cases of pneumoconiosis increased greatly in miners who had worked underground over 20 years.

Many questions remain unanswered such as what kind of dust causes the disease, what changes in lung tissue lead to progression of coal workers' pneumoconiosis and why some persons develop progressive massive fibrosis while others do not. Research and investigation is now going on not only to find answers to the problems of coal workers' pneumoconiosis but also to discover ways to prevent many of the respiratory diseases which cause so much illness and lost time in industry.

Studies of random samples of coal mines in the United States have shown the prevalence of coal workers' pneumoconiosis to be about ten per cent in working miners. About one-third of these have complicated pneumoconiosis.

Prevalence studies of coal workers' pneumoconiosis made by the PHS in 1964 showed that in Eastern Kentucky (Harlan and Letcher counties) 10.9 per cent of the working miners studied had x-ray evidence of pneumoconiosis and 32.1 per cent of these had the complicated form. In Western Kentucky (Hopkins county) 5.7 per cent of the miners were found to have x-ray evidence of the disease and none had complicated pneumoconiosis.

In the non-working miners in Eastern Kentucky, 17 per cent had pneumoconiosis and 84 per cent of these showed complicated pneumoconiosis. In Western Kentucky in non-working miners 9.3 per cent had pneumoconiosis and 60 per cent of these had complicated disease. These figures for non-working miners show that long exposure to mine dust greatly increases the proportion of complicated cases.

The above figures for Kentucky are based on small numbers and can only give an indication of the extent of the disease here. However, in the same survey larger numbers of miners were x-rayed in Appalachia and approximately the same figures prevailed.

A prevalence study shows how many cases exist at a given time. In such a study it is necessary to take a cross-section of the miners involved.

The PHS made a study of death rates for United States coal miners. The study showed that in 1950, the death rates of coal workers were nearly twice that of the general working male population and that the death rates from diseases of the respiratory system in miners were five times greater than in the male working population as a whole.

There is no known treatment for coal workers' pneumoconiosis. Prevention seems the best approach to control at this time. Dust control is the most important preventive measure.

In an effort to reduce the dust in the coal workers' environment much research is being done. New cutting and filtering techniques for the prevention and control of dust are being developed. New processes, new types of equipment and improved education and training practices must be applied if the health and safety of the worker in the coal industry are

to be improved.

Another preventive measure in the control of coal workers' pneumoconiosis is the provision of a medical program to evaluate the physical condition of the coal worker. An initial chest x-ray repeated every five years or oftener is essential. Pulmonary function tests and medical and occupational history must be included. Medical care should be provided.

One of the great needs in combatting the problem of coal workers' pneumoconiosis is to provide for rehabilitation of the worker. Many of these men after medical evaluation can be assured that they can work and earn a living in some type of work where dust exposure is less. Provision must be made for vocational training and jobs made available so that these men can continue to be self supporting.

One of the problems facing the physicians in the mining areas of Kentucky is how to advise the coal worker who has simple pneumoconiosis with few or no respiratory symptoms. One physician in a small mining community in Eastern Kentucky with a stack of examination records before him summed up the situation by saying that all these miners showed x-ray evidence of pneumoconiosis but he could not say that they were disabled. Yet he felt that he should not let these men return to the dusty environment in the coal mines where their simple pneumoconiosis might progress. Coal mining is all these people know. There are few or no other industries in the area. If dust conditions cannot be improved in the mines, training these men for other work and making jobs available seems to be the only answer.

A thorough and comprehensive study to evaluate the problem of coal workers' pneumoconiosis and steps for its control are needed in Kentucky.

Following the recommendation of the Governor's inter-agency council on industrial health and safety, the Department of Mines and Minerals and the Department of Health are surveying the respirable dust concentration in Kentucky coal mines. Composition of the dust and other factors are also being studied. This survey started March 21, 1969.

The Kentucky Department of Health, working with the Department of Mines and Minerals, is preparing to take the necessary steps for the control of pneumoconiosis in this state. The Health Department will ask for federal funds to initiate a program to determine the prevalence of coal workers' pneumoconiosis in Kentucky. This will include chest x-rays, pulmonary function tests, medical histories, and histories of exposure to coal dust and other contaminants. Dust concentration measurements will be continued in the mines and related facilities along with engineering studies to suppress and reduce the respirable dust generated by the various methods of mining. Since the only effective method to prevent the progression of the disease is to remove the miner from exposure to high levels of coal dust, adequate vocational and rehabilitative services will be made available for those who are shown to have pneumoconiosis.

The successful control of the problem will depend on the continued close cooperation between the Department of Health, the Department of Mines and Minerals, other State Departments and all who are involved.

A Physician's View of Physical Education†

Allan J. Ryan, M.D.

A model of complete physical education for all ages and grades is described. The relation of physical fitness to good health is discussed.

It is just a little over 100 years since Lewis B. Munroe was appointed director of physical and vocal gymnastics in the Boston Public Schools. That was in 1865, and in the next year the first state law making physical education mandatory in public schools was passed in California. It provided that regular instruction and attention be given to

> "Such physical exercise for the pupil as may be conducive to health and vigor of the body as well as the mind".

The rules clarifying this law stated,

> "In all primary schools exercises in free gymnastics shall be given at least twice a day and for a time of not less than five minutes for each exercise."

President Stearns of Amherst College in 1854 announced the establishment of a department of hygiene and physical education under a professor. It was stipulated that the professor would have to have a degree in medicine and training in gymnastics. Edward Hitchcock, M.D., satisfied these requirements and became director of the department in 1861. Among other things he organized the first intra-mural sports in this country.

Dudley A. Sargent, M.D., began his teaching career as a gymnastics instructor at Bowdoin College, subsequently enrolled as a student, and after taking his degree, graduated from Yale Medical School in 1878. He became director of the Hemenway Gymnasium at Harvard in 1880 and subsequently founded Radcliffe College for Women. Edward M. Hartwell, M.D., director of the gymnasium at Johns Hopkins from 1883-1890, and William G. Anderson, M.D., of the Adelphi Academy in Brooklyn, and later at Yale and the New Haven Normal School, and Jesse Feiring Williams, M.D., at Columbia were other medical pioneers in physical education.

It can therefore be truthfully said that the development of physical education in this country owes a tremendous debt to physicians. From the fifth century B.C. down to the Nineteenth century, studies in the physiology of exericse and in rehabilitative and therapeutic gymnastics were carried out almost exclusively by physicians. That these subjects are studied and taught today by non-medical persons is a modern phenomenon.

Why did it come about?—chiefly because of the development of modern therapeutics beginning with the discoveries of Pasteur, Cohnheim, Ehrlich and others, and the discovery of general anesthesia which made modern surgery possible. Physicians changed the orientation of their practices from the use of empiric medications, physical treatments and the prescription of preventive and therapeutic gymnastics to a more rational chemotherapy, later biotherapy and surgical approaches to the eradication of disease.

One hundred years later, when infectious diseases appear to be coming under effective control and surgical advances seem to have approached their ultimate goal with the successful transplantation of organs, the chief threats to health and longevity of life are the chronic degenerative diseases. Physicians are more and more returning to their former preoccupation with preventive disease and have "rediscovered" that one of their best methods is the prescription of exercise.

The value of exercise in preserving health and prolonging life is becoming more and more apparent. Good health is now seen not as a negative state, ie., the absence of disease, but as having a strong positive component, which, for lack of a better term, we describe as "physical fitness". Although life expectancy for the average man has gradually increased in the past half century in the United States from 49

†*Presented at the fourth general Session, 1969 KMA Annual Meeting, September 25, Louisville*

to 67 years, the high rate of morbidity and mortality due to cardio-vascular disease, and especially disease of the coronary arteries, in the 45 to 60 years age group is responsible for the fact that the expectancy of years for the 50-year-old man today is no better than it was 50 years ago. Yet of the ten major risk factors for occlusive disease of the coronary arteries listed by the American Heart Association, eight can be favorably modified by regular exercise of a vigorous nature.

If, as concerned physicians, we are going to persuade the people of the United States to adopt regular exercise as a lifelong habit, how should we attempt to go about it? Many approaches are being recommended, but it seems most likely that it is only by a continuous process of education, beginning in the first years of school that we as a people can accomplish this objective. Can we physicians think of anything more important to teach children than how their bodies can function effectively to meet the ordinary physical demands of life, to be prepared for the phycical emergencies they will encounter, and to satisfy safely the natural desire for healthful physical recreation?

Many people have a very limited understanding of what constitutes a comprehensive program of physical education. Frances Doster, M.D., five years ago described a model to illustrate the ideal program of elementary and secondary school physical education. The pupils are depicted as a beam of sunlight being dispersed through the prism of physical education into a broad spectrum of activities. At the top Doctor Doster placed interscholastic sports and at the bottom adapted physical education, as representing the extremes of the range. In the central bands of the spectrum are displayed extramural and intramural sports, field and play days, and regular physical education classes. Somewhere within this array of activities every school child should find their place. Unfortunately this expectation today in many school systems is still far from the reality.

Every aspect of physical education can make some contribution to the physical fitness of our young people, girls as well as boys. It would seem unnecessary in this age when adult women have more nearly achieved equality with men in many fields of activity than at any time in recent history to have to stress the fact that physical education is for girls as well as boys. Yet only a few years ago I read of a high school basketball coach resigning his position because the school principal ruled that girls should have the use of the gymnasium one hour in the afternoon two days a week. Girls' interscholastic and women's intercollegiate sports are not as widely practiced and do not attract as many participants as those for boys and men, and perhaps they never will. It is important that we continue to make more opportunities available to those girls and young women who have the desire and need for this type of healthful competition.

The various aspects of the physical education program should not be confused with each other, since each satisfies a certain need and offers a different experience. For the boy or girl who has a strong competitive spirit and is talented in sports skills, the interscholastic program offers a challenge and an opportunity. The challenge is to measure your ability against the best and to discipline yourself in mind and body so that you are capable of your best performance. The opportunity is to learn how to control your body through direct participation in a variety of activities, to learn how to cooperate effectively with others as a member of a team, to learn to respect yourself and your opponent, and perhaps to learn about other people and places through travel. A football coach who asked his quarterback in a climactic game to attempt a two-point conversion, which failed, in the last minute of play, and saw his team defeated by one point was asked why he did not elect to take the almost certain one-point conversion for a tie result. He replied, "My job is not to win football games but to teach young men how football games can be won."

I invite you to compare this with the more celebrated remark by another well-known coach that, "Winning is not the most important thing (in football), it is the *only* thing!"

Which better exemplifies the ideals which competitive sports are expected to instill in young people?

Participation in interscholastic sports should never be considered to be a substitute for regular physical education classes and intramural sports. Clarke and his associates in the Medford (Oregon) Boys Growth Study have shown that boys participating in interscholastic sports where the physical education classes were of poor quality showed lower physical

fitness indices than non-athletes in schools where these programs were rated very good. Interscholastic athletes in the schools with good physical education classes rated highest of all. Boys who attended schools where interscholastic sports start as early as the fifth and sixth grades may become outstanding athletes in junior high school, but if they have not enjoyed a well-rounded physical education program, they lose out to the physically better prepared boys in high school and college.

Extramural sports in physical education represent a half-way step between the interscholastic and intramural programs. A distinction must be made between them and out-of-school sports programs sponsored by individuals or organizations where participation rather than education is the goal. The school extramural programs that are the responsibility of physical education teachers, rather than special coaches for each sport, tend to enlist a broader segment of the school population than the interscholastic program, and are organized and operated more informally. In the absence of organized interscholastic programs for girls in some places these extramural spots have helped to fill the need for outside competitive activities. In general, they could be said to have the same objectives as interscholastic sports, but at a much less intense level of activity.

Intramural sports programs provide a practical laboratory for the exercise of skills and qualities developed in the regular physical education classes. They also provide competitive opportunities for those not skilled enough or sufficiently motivated to compete on the interscholastic level. There should be no attempt to duplicate the list of interscholastic sports, particularly those games which require a high degree of organization, a large number of players per squad and expensive equipment. The schedule should include as wide a variety of sports opportunities as possible, including types of sports not practiced on an interscholastic level in that school.

In the school year 1968-1969, a survey by the National Federation of State High School Athletic Associations showed that 28 different sports were reported by the schools in the 50 states, District of Columbia and six Canadian provinces. A distinction was not made between interscholastic and intramural and extramural participation. There was a total of 3,456,380 participants. The number of individuals could not be distinguished. but it is certain that there were a considerable number who were registered for more than one sport. Some of these are primarily interscholastic, some extramural and some intramural. Some may be practiced in all three settings, and some may be interscholastic in one school and intramural in another.

Schools which offer a greater variety of sports activities offer opportunities for participation to more students, a greater chance for all students to learn a variety of skills and develop different physical qualities, especially those which may be most useful to them after they finish school, and in each season the possibility of a full schedule of participation.

Field days and play days offer additional opportunities for intramural and extramural competitions in a variety of unusual games and sports activities which cannot be included in the regularly scheduled program for interclass and intraclass competitions, and for demonstrations of special physical education projects on which students and faculty may have been working. They provide a focus on physical education activities for the year, stimulate school spirit, and draw attention to the important role which physical activities play in the school program.

Regular physical education classes should not be devoted to playing games or intramural sports exclusively. These have their place, depending on the amounts of time which can be allotted to the whole program. The time assigned to physical education should be adequate to achieve the objectives which the department sets for itself. We should no longer have to contend with situations where the hours of the school day are first scheduled for academic subjects, and the remaining time, if any, allocated for physical education.

It is desirable, but not absolutely essential, that a period of physical education be scheduled for every school day. This is not unreasonable when the total number of hours spent in other classes and school activities is considered. It is not reasonable,however, to expect that the objectives of any worthwhile program of physical education can be met in less than two periods a week. This should be the absolute minimum, with three to five periods considered more desirable. It should be remembered in scheduling these periods that time is required for changing

clothes before and after activity, and that working time may be only half of that allocated.

Every school grade should have a physical education program. The fact that this ideal is rarely realized in this country is due to our failure as citizens to supply the schools with adequate facilities, qualified teachers and supervisors, and administrators and school boards who demand that such realization occurs. As physicians who should be concerned with the preventive as well as the therapeutic aspects of medicine, we must bear a major share of the blame for not speaking up for these things at every opportunity in our social, professional and other community contacts.

Tremendous pressures have been exerted on our towns and cities in the past 30 years to build new schools because of the rapid growth of our school age population. Everyone recognizes the familiar story of school construction today. The needs are recognized by the school board and a plan to build a new school put forward. The architect is hired and plans are drawn. These will ordinarily include facilities for physical education, which may or may not be adequate depending on the instruction given and the knowledge of an interest in physical education on the parts of the board and the architect. Cost estimates are prepared and a bond issue based on them is voted. All this takes considerable time before construction begins. It soon becomes apparent, once building has started, that the cost will outrun the monies available. It becomes necessary to modify the original plans. The word is passed to "cut out the frills." This invariably means that physical education facilities will be among the first to be cut back or sacrificed entirely. In the case that an existing school must be enlarged to meet an increased pupil load first thoughts are given to classrooms and supporting services. How often are the facilities for physical education enlarged or expanded? More than likely some of the land used for recreational purposes is taken away for the new building and no new land acquired.

Qualified teachers of physical education are seldom hired in numbers adequate to meet the needs. Physical education teachers may be expected to handle 100 or more students at one time and total loads of 500 students. It is no wonder that so many physical education classes become periods of games and free activity rather than learning experiences.

A majority of our elementary schools do not have even one qualified physical education teacher or supervisor. Some school systems don't have a single supervisor of physical education for their entire group of elementary schools. Consequently, the burden of providing the program of physical education is thrown entirely on other teachers, who may have little or no training in how to conduct such a program, and perhaps even less desire to attempt it. So-called "recess" or "play periods" become largely a baby sitting activity and a major disciplinary problem which most teachers will avoid in any way possible. The gradual conversion of teacher training colleges into liberal arts colleges and universities, whatever else good it may have accomplished in elevating education standards, has further diminished the number of teachers not majoring in physical education who are qualified to teach it at any level.

In Canada this year compulsory physical education for all schools has been abolished by a federal law. This doesn't mean that physical education will immediately disappear. but schools will, because of this law, have an increasingly difficult time in justifying their programs in the face of mounting expenses and the pressures of other interests.

Programs of physical education should be structured so that they are progressive from the earliest to the highest grades, and so that they are responsive to the particular needs of each age group. In this way a complete range of activities can be covered without unnecessary duplication and boring repetition, the young student is properly prepared for his future participation in sports at every level, and the general qualities of physical fitness are appropriately developed. One cannot assume that all these objectives will be automatically achieved by any program no matter how it is offered or how assiduously pursued unless they are specifically recognized and planned for. Cumming and his associates have demonstrated that endurance fitness, for example, is not necessarily produced by 135 minutes of physical education classes a week plus participation in team sports unless endurance activities are deliberately included in the program.

Individual variability in size and maturity must be allowed for in planning the physical education program. Matching of boys and girls

for team games and sports is important even within the limits of one grade where almost everyone is of the same age. Some boys and girls excel in physical activities in elementary school but not in junior high or high school. Others excel first at the junior high or high school levels. Failure to progress within the normal range of growth may first come to the attention of physician or parents through the observations of physical education instructors.

The needs of the exceptional school child. whether physically handicapped or mentally retarded, must be recognized and met by programs of adapted physical education. Many schools are completely lacking in such programs and others have them in name only. Where they do exist, too often they are time-passing activities rather than programs designed to improve the physical capacities of the affected children. A comprehensive program of adapted physical education may include specific rehabilitative measures as well as attempts to improve work capacity and to teach physical activity skills. It is important to remember that a good adapted program may be carried out without specific rehabilitative measures and without elaborate and expensive equipment. All that is necessary is a teacher who is trained in the principles of this form of physical education and has had some practical experience in applying them.

The best program of adapted physical education is one which puts primary emphasis on the improvement of functional capacity. There are very few students indeed, no matter how handicapped, who cannot participate to some extent in such a program. Every handicapped, physically immature or mentally retarded student can benefit from participation. Functional capacities in endurance, strength, coordination, balance, speed and other qualities are measured before and after participation. In the classes, emphasis is placed on continuous activity for all participants with instruction coinciding with the appropriate activity rather than replacing it.

The complete physical education program in which I have outlined for you the needs and interests of every school child for vigorous physical activity and healthful recreation can be met. The fact that these needs are not being fully met is the responsibility of every citizen. It is particularly the responsibility of physicians who should understand the reasons for such a program, have the knowledge to explain it to those who can implement it, and have an obligation to the community at large to promote it as an important segment of preventive medicine.

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Appendicitis in a Small Community Hospital

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A five year review of appendectomies in a small community hospital is presented. Various aspects pertaining to diagnosis and treatment are discussed. A morbidity of 8.9 per cent and a mortality of 0 per cent were noted. More reporting from community hospitals is encouraged.

IN A 1967 study of 1,118 hospitals, appendicitis was found to rank twelfth among the 50 leading causes of hospitalization[1] and appendectomy third among the 50 most frequent operations[2]. In the Appalachian Regional Hospital, appendectomy ranked third after cholecystectomy and inguinal hernia repair during a five year study period.

The present day hospital mortality rate for acute appendicitis probably approaches one per 1,000 patients when considering the 50 leading causes of admission[3]. In many reported series[4,5,6,7,8] it is less than one per cent.

This study is intended to present the results of the surgical management of acute appendicitis in a 60-bed community hospital during the period of July, 1964 to July, 1969.

General Considerations

Because of the procedural arrangements at our hospital, most patients who arrive at the out-patient department complaining of abdominal pain are first seen by the surgical service. This attitude, we feel, has resulted in a faster and more definitive diagnosis, since it is indeed the surgeon who decides on the necessity of operative intervention. In this study, 83 per cent of the patients were so classified, with the remaining being referred by the medical staff of the hospital or from area physicians.

All patients in whom a diagnosis of acute appendicitis is made are prepared for immediate surgical intervention. Ninety-five per cent of the group were so treated and no difficulties were encountered. We do not feel there is any place for the conservative management of acute appendicitis[9]. There is usually ample time preoperatively to restore the patient to as near a homeostatic state as is possible.

Delay in diagnosis still remains somewhat of a problem. It is precisely in these cases where morbidity increases. In this study, four (five per cent) of the patients were encountered and all four had complicated post-operative courses. They consisted of two females, ages eight and 16 and two males, ages 36 and 67. Three of the four had abscess formation and one a gangrenous appendix without perforation at the time of surgery.

Results

During this study period a total of 67 appendectomies were performed, all having the pre-operative diagnosis of acute appendicitis. There were 42 males and 25 females with an average age of 18.6 years; the youngest being five years and the oldest 67 years.

Of the 67 cases, seven proved to have an incorrect pre-operative diagnosis. This gives a correct pre-operative diagnostic rate of 89 per cent. Of the correct diagnoses, the lowest total white count was 8500 and the highest 39,500 with an average of 19,300. Of the incorrect group, the lowest total white count was 9000 and the highest 22,000, with an average of 15,250.

The pathologic tissue diagnoses were as follows: gangrenous appendicitis, 29, (44.2 per cent); suppurative appendicitis, 11, (16.6 per cent); acute appendicitis, 20, (28.7 per cent); appendix unremarkable, 5, (7.5 per cent); appendix with lymphoid hyperplasia, 1, (1.5 per cent); and mucocele of appendix, 1, (1.5 per cent).

The complications encountered in this series were as follows: pulmonary, three; wound infection, two; pelvic abscess, two; ileus, one;

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retroperitoneal seroma, one; seroma of wound (negative culture), one. This accounted for a total of ten complications occurring in six patients giving a morbidity rate of 8.9 per cent. There were no deaths in this study.

Discussion

Although the pre-operative rate (89.9 per cent) of correct diagnoses is quite acceptable, further analysis of the seven incorrectly diagnosed cases revealed one appendix to have lymphoid hyperplasia and another to be a mucocele of the appendix on pathologic examination. At operation in the remaining five cases, the following were found: mesenteric adenitis, three; an infarcted ovary, one; and an acute serous synovitis of the right hip joint, one.

The diagnosis of acute appendicitis continues to be based on clinical findings. A careful history and physical examination are the hallmarks of obtaining an accurate diagnosis. There is no such thing as a white count confirming the diagnosis. This study showed very little difference in total white counts between the correctly and incorrectly diagnosed cases. Furthermore, in the overwhelming majority of cases in this series, decision to operate had been made well in advance of knowing the result of the white count. This attitude is especially important in children who tend to react quite efficiently with an elevated white count in most types of infection.

The single most important physical sign that we have found to be of use and to be reliably accurate is percussion tenderness. This invariably signifies intra-abdominal pathology (peritoneal irritation) and coupled with the history and remaining portion of the physical examination has been most accurate in our hands. It goes without saying that any diagnosis is rarely ever based on one sign or symptom. We do not feel that x-rays play any significant role in the diagnosis of acute appendicitis, but may be most important whenever the diagnosis is in doubt, especially in infants and younger children.

Although we recognize the difficulties encountered when one examines children, we have not found this to be a significant problem in making an accurate diagnosis. A good number of these cases include children under 10 years of age. What has been generally underrated, especially in surgical circles, in the evaluation of a sick child is precisely the child's general behavorial disposition at the time of examination. Our experience has shown that a child who presents with an acute surgical abdomen is rarely belligerent to the gentle examiner. The essence of examination in children can be summed up in the following words: "gentle, friendly consideration".

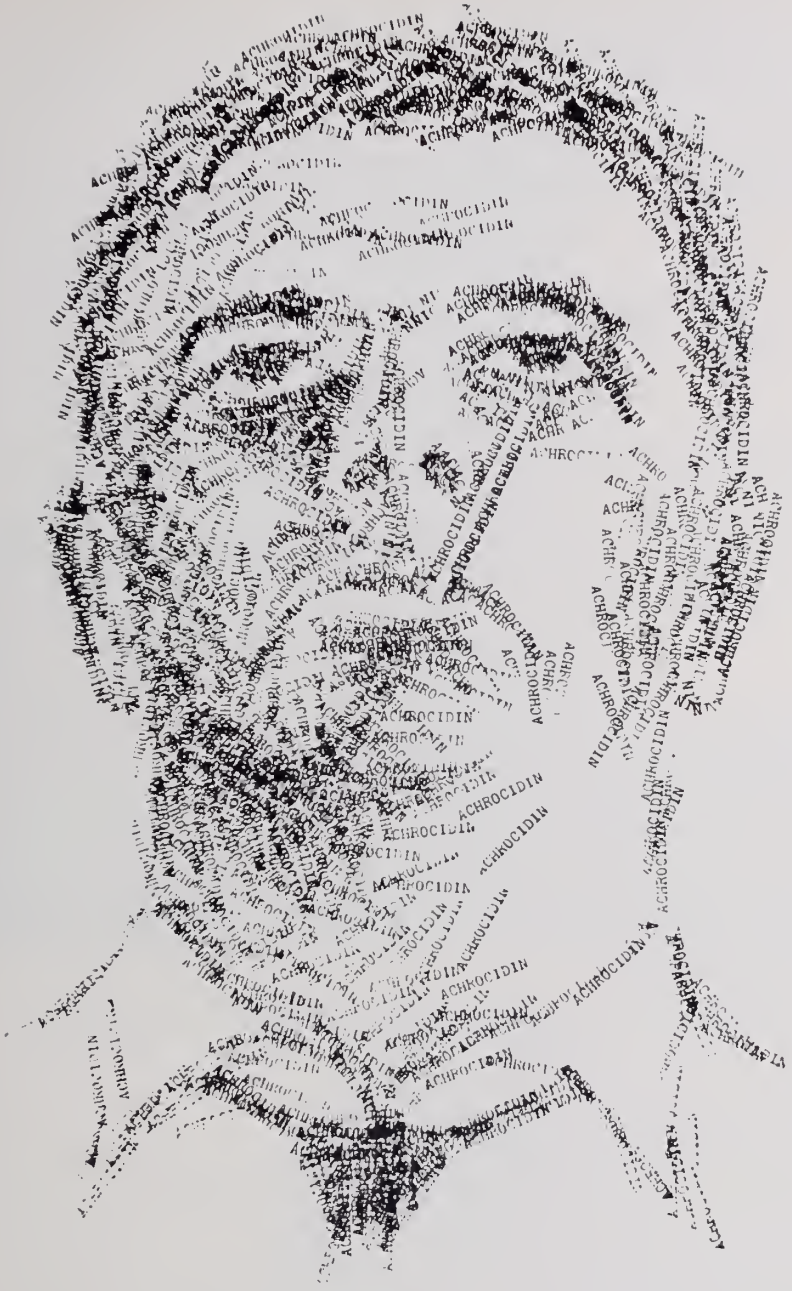
A good number of the cases included in this study were moderately or far advanced when first seen by the physician. Seventy and eight-tenths per cent had a pathologic diagnosis of gangrenous (with or without perforation) or suppurative appendicitis. The majority of complications (70 per cent) occurred in these cases. Many reports indicate that the incidence of perforation of the appendix has changed very little in the past 30 years[8]. Our study not only confirms this impression but further indicates that it is probably greatly due to procrastination on the part of the patient and/or parent rather than the physician. In this study, the overwhelming majority of patients were operated upon shortly after admission. Delay in diagnosis occurred in five per cent of the series and all of these patients had complicated post-operative courses.

It was possible to perform a definitive appendectomy in all cases. All abscess cavities were drained externally without concomitant drainage of the wound. We see no advantage of drainage in the presence of generalized peritonitis, although the peritoneal cavity is thoroughly cleansed with saline solution usually containing kanamycin antibiotic. This policy, however, may not be the most feasible approach to the same problem in the young child or infant[10].

Two patients required re-operation, one for a pelvic abscess and the other for drainage of a retroperitoneal seroma. This latter was performed at a subsequent admission some four weeks post appendectomy after what appeared to be a benign post-operative course.

It is this writer's opinion that the true morbidity and mortality rates of the surgical treatment of appendicitis are far from being precisely known. Although preliminary studies indicate that the latter approaches one per 1,000 patients when considering the 50 leading causes of admission[3], the true incidence will probably never be known until reports are obtained from the greater majority of community hospitals.

(Continued on page 123)



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SPECIAL ARTICLES

The Role Of A Medical Society In A Drug Abuse Program

CHARLES BARON, M.D.

IN May, 1968, the commonwealth attorney of Kenton County, Kentucky, felt that a drug abuse educational program was needed there. The idea was initiated when he talked with three young boys and their parents who were there because of a drug charge. In the three previous years, the number of drug cases coming before the attorney had suddenly increased. Particularly in the case of marijuana, with the severe penalties of the Kentucky law, in line with Federal laws, it was felt that prevention was better than prosecution.

On July 30, 1968, a meeting was held with 35 school officials. They were presented with the problems in Kenton County schools. A film on LSD was shown and a discussion followed. A questionnaire answered by those attending revealed: 91 per cent agreed that a program should be held in the two colleges; 82 per cent felt that a program should be held in the senior high schools; 54 per cent felt that it should be held in the junior high schools. None wanted it in the grade schools.

With this backing, the commonwealth attorney appeared before the Campbell-Kenton County Medical Society and asked for aid in two areas. One, to furnish funds to buy two films, one on marijuana, the other on LSD. It was approved. Second, it was requested that a physician be present at each program on a volunteer basis. The author felt that to be able to do this, the physician must be knowledgeable. The chairmanship was gladly accepted by the author but with many misgivings. The author's experience in the mental health field, with access to the literature, posed a challenge in community relations and education that could not be denied.

The commonwealth attorney collected and produced material for a pamphlet. The materials were selected from the publications prepared by the Bureau of Drug Abuse Control of the Food and Drug Administration, U.S. Department of HEW, Smith Kline and French Laboratories and the Federal Bureau of Narcotics. This resulted in a 20-page booklet, which was published free of charge as a public service by the Union Light, Heat, and Power Company. Twenty thousand were printed and 19,000 of these were distributed.

The front cover has a wavy psychedelic black and yellow design. The title on the cover is "here are the facts, now it's your decision." The inside of the cover has the following note. "YOUR DECISION is dedicated to you students, our future leaders, so you can make your own and intelligent decision. Life is full of problems.—Is there a solution to them contained in these pages? This information is made available to you through the courtesy of the Campbell-Kenton County Medical Society and the Kenton County Commonwealth's Attorney's office."

The next page contained the following—

"Dear Student:

The information contained in this booklet can be read and understood in approximately 15 minutes.—Can you spare 15 minutes to save your life from ruin? Man's free will is his most precious possession—it can be used to build or destroy. A foolish mistake, on a dare or in the spirit of going along with the crowd, can destroy your entire future life. As a law enforcement officer, I realize that the vast majority of you in Northern Kentucky are intelligent enough to overcome the shallowness of temptation in the use of drugs. However, with the use of facts contained herein, you may prevent a schoolmate, a friend or a neighbor from making the fatal mistake, merely because he or she did not have the same good judgement you possess. Trusting you will read this booklet and then the decision is YOURS.

Sincerely yours,
John J. O'Hara,
Commonwealth Attorney
Kenton County

The table of contents consisted of the following headings. Introduction; Historical Background; Glue Sniffing; Depressants; Stimulants; Marijuana; LSD-25; Narcotics; The Impact of the Law on the Student's Future; Illegal Traffic in Dangerous Drugs; Statements to Ponder; What You Can Do and Definition of Terms.

The author made up kits for the physician participants which contained the following materials: The above described booklet "here are the facts, now it's your decision"; the AMA kit "Drug Abuse Information Program"; "Drug Abuse: Escape To Nowhere, A Guide For Educators" available from the National Educational Association, 1201 Sixteenth St. N.W. Washington, D.C.

The number of people reached was approximately 20,000. This figure did not include two television programs from station WCPO. Appearances were made before 32 schools, 11 churches, 19 Parent

Teachers Associations and 27 clubs and civic groups, a total of 89 groups. In the last group, it is interesting to note, were the local mental health association with two programs, American Red Cross, Community Centers, Community Youth Counselors, Kenton County Police, Kentucky State Sheriff's Convention and the Ministerial Association. This entire group is stressed because key people were reached who could use the material in their particular discipline.

Physicians participated in these programs 41 times or 42 per cent of all the programs. Eight per cent of the medical society was involved. The distribution by category was as follows: six general practitioners-30 programs; two psychiatrists-four programs; two internists-two programs; one pediatrician-three programs; one obstetrician-gynecologist-one program. One physician participated 16 times; one five times; 1, four times; three, three times; one, two times; five, one time.

The use of general practitioners was most important, since they were more willing to participate in the program. They usually participated in the community where they practiced and therefore were accepted more completely as the familiar authoritative figure in the medical life of the area.

Summary

A local commonwealth attorney recognized a need for education in drug abuse as a preventive measure in illegal acts which could jeopardize the future of adolescents.

The Campbell-Kenton County Medical Society was asked to finance the purchase of films and form a speakers bureau as part of the team approach of law and medicine. The medical society responded to a community social project similar to that held for polio immunizations.

The interest and participation of the audience in the question and answer periods were beyond expectation. This type of response suggests a possible ongoing program in medical education. Concern about the problem was definite and bewildering. At times, personal feelings evoked rigidities of a broad social sense. The audience arousal revealed the increasing uncertainties of the present asocial, provocative, challenging behavior. It seemed to reflect a helpless attitude, leading in some instances to acute anxieties and expressions of fright.

The learning process of the experience of the commonwealth attorneys and their assistants was prodigious. It was evident that learned facts and attitudes contributed to a maturing climate as the experience grew in scope and time.

The learning process of the doctors, from reading literature and facing perplexed and challenging audiences, made an impressive imprint. From a social and community impact, this experience drew latent social awareness and responsibility in community problems. This type of involvement, far from the one-to-one office relationship, in a dynamic group expression, created an awareness and crytallized abilities and capacities for civic interests. The image of the medical profession grew immensely as appreciation was expressed from group after group. The verbal pat on the back brought forth at medical meetings a ray of hope that the much maligned medical profession, the favorite target of conversation and popular writing, presented a picture and posture not often seen.

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EDITORIALS

Foreign Medical Trainees

IN THE past generation the United States has become the world center for postgraduate medical training. There are now in excess of 15,000 graduates of foreign medical schools in internships, residencies, research and other programs in this country. They come at the rate of 7-8,000 a year from schools in 95 different nations. The ten providing the greatest number are in order: Philippines, India, Korea, Thailand, Iran, Formosa, Spain, Argentina, Mexico and Germany. More than 3,500, or nearly 24 per cent of the total, come from the Philippines; nearly 2,000, or over 12 per cent come from India. About 20 per cent of the recent additions to our profession have come from foreign medical schools. A comparatively small number of these are American citizens who have studied medicine abroad.

Success in any endeavor is much to be desired, but in this regard it has become rather overwhelming and in the minds of many constitutes a complex problem. It is creditable for us to offer the best medical training available to those who wish to receive it; the primary objective has always been to furnish for physicians of less ample medical facilities what we have to offer in order that they may take back to their countries a better quality of medical care. It appears however that such an aim is defeated when the trainee changes his mind and desires to remain as an addition to our more adequate supply of physicians rather than return to his own country where the need is so much greater.

Kelly M. West, M.D., professor of medicine and continuing education at the University of Oklahoma School of Medicine, writing in the Federation Bulletin of State Medical Boards, has acknowledged that we have a problem, has gone into considerable detail in explaining it and offers some viewpoints well worth consideration. He remarks that "actually the percentage of foreign house officers is greater in the United Kingdom than in the United States, and no migration to the U.S. can match in some respects the exodus of physicians from North and South Vietnam to France. The exact size of this migration is not known but many observers believe there are more Vietnamese physicians in France than in both South Vietnam and North Vietnam combined. The Philippines, Greece, and Argentina need more physicians, but they are all producing more than their economies can support. Our studies in Latin America and other experiences indicate that an overwhelming majority of foreign trainees would prefer to return to their own countries. Moreover, they will regularly do so even when financial opportunities in their homeland are substantially less than in the United States. It was clear that almost all of these people are willing to work in their own countries at salaries less than one third of the U.S. standards. Only when conditions of working and living are extremely difficult or impossible was migration frequent."

The urban-rural imbalance of physician supply is even worse in these countries than in our own. The large cities are amply supplied with physicians and modern medical facilities but the smaller towns and rural areas are tragically deficient.

The United States is better supplied with physicians and modern hospitals than any other country; yet we are seemingly in short supply everywhere. We seem always to be able to use to good advantage those foreign born and educated physicians who even nearly meet our standards of ability and who find a way, by accepted means or otherwise, to stay. Yet we seldom urge or encourage them to remain with us permanently. Our standards of licensure are

Table I

	KY.	IND.	ILL.	MO.	TENN.	VA.	W. VA.	OHIO	Total
Total additions in 1968	206	330	343	247	133	267	37	401	1964
# from foreign schools	20	110	96	11	2	81	3	26	349

reasonable, but not too high, and our restrictions for immigration are reasonable. There are many Americans who would ease our license regulations and encourage less rigid citizenship requirements, but generally we do not believe this should be done.

To equalize our standards of admission for training or permanent visas the Educational Council for Foreign Medical Graduates was incorporated in 1956 and began operation of the ECFMG medical examinations the following year. This examination is given in all countries from which our foreign candidates come, or after their arrival in the United States. Certification by this examination is regarded as evidence that the candidate has medical knowledge at least comparable with the minimum expected of graduates of approved medical schools in the United States and Canada. It is a screening test designed to determine whether the candidate has a medical education adequate to admit him to postgraduate training here; it is not a test of his competence to practice medicine in our country. In Kentucky, as in most other states, the test is used as a basis for temporary or limited license only. In 1968 there were 19,548 candidates taking this examination. The failure rate was high, approaching 50 per cent; it must be stated that inability to understand the English language well undoubtedly accounted for many failures. We have now in many of our state institutions foreign graduates employed who never took this examination, since it was not generally used before 1957.

A review of our regulations governing the training and licensing of foreign trained physicians indicates that we in Kentucky are neither more nor less restrictive than in 46 other states. The State Board of Health is often criticized because our licensing restrictions are too lax, and at the same time we are urged by individuals and the daily press to be less rigid and in repeated instances to waive our own rules. It is of some interest to compare ourselves with our neighboring states.

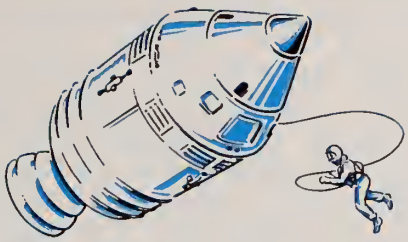
Table I gives the number of additions to our medical profession by license or reciprocity in 1968 and the number of percentage of those who are graduates of foreign medical schools. It would indicate that this section approaches the national 20 per cent and that Kentucky, with a little less than ten per cent, is lower than average for the area.

Doctor West concludes his excellent article: "In recognizing the difficulties created by these large scale temporary and permanent migrations we should not lose sight of the advantages and potentialities of this phenomenon. These problems are, to a considerable degree, symptoms of success. This migration of trainees should be looked upon, not so much as a problem to be eliminated, but as an opportunity to exploit our great resources and capabilities in furthering international health. All of us are immigrants or descendants of immigrants. If we wish to help the under-privileged countries, a variety of methods are open to us other than prohibiting the entry of foreign physicians. We can, for example, work with these countries to improve their own training programs and career opportunities.

"The migration of physicians is in many instances regrettable but it does dramatize the need to improve conditions in the donor countries, and the losses serve as a stimulus for corrective actions. We may wish to join with certain nations in limiting the number of physician migrants, but I think it would be a mistake to close the door entirely even to physicians from poor countries. Most of us would agree that we ought to increase greatly the number of domestic graduates so that we would not be tempted to recruit physicians from foreign countries as a direct manifestation of public policy. Unfortunately, our dependence on foreign graduates has reached a level where it will be increasingly difficult to reduce the flow from abroad even if we wish to do so.

"To be sure, these foreign medical graduates have created some problems for us and for their native countries, but we should not lose sight of their present and potential value to us and our value to them. It is not wholly regrettable that physicians from all over the world wish to come to our country to train, to work, and to live."

SAM A. OVERSTREET, M.D.



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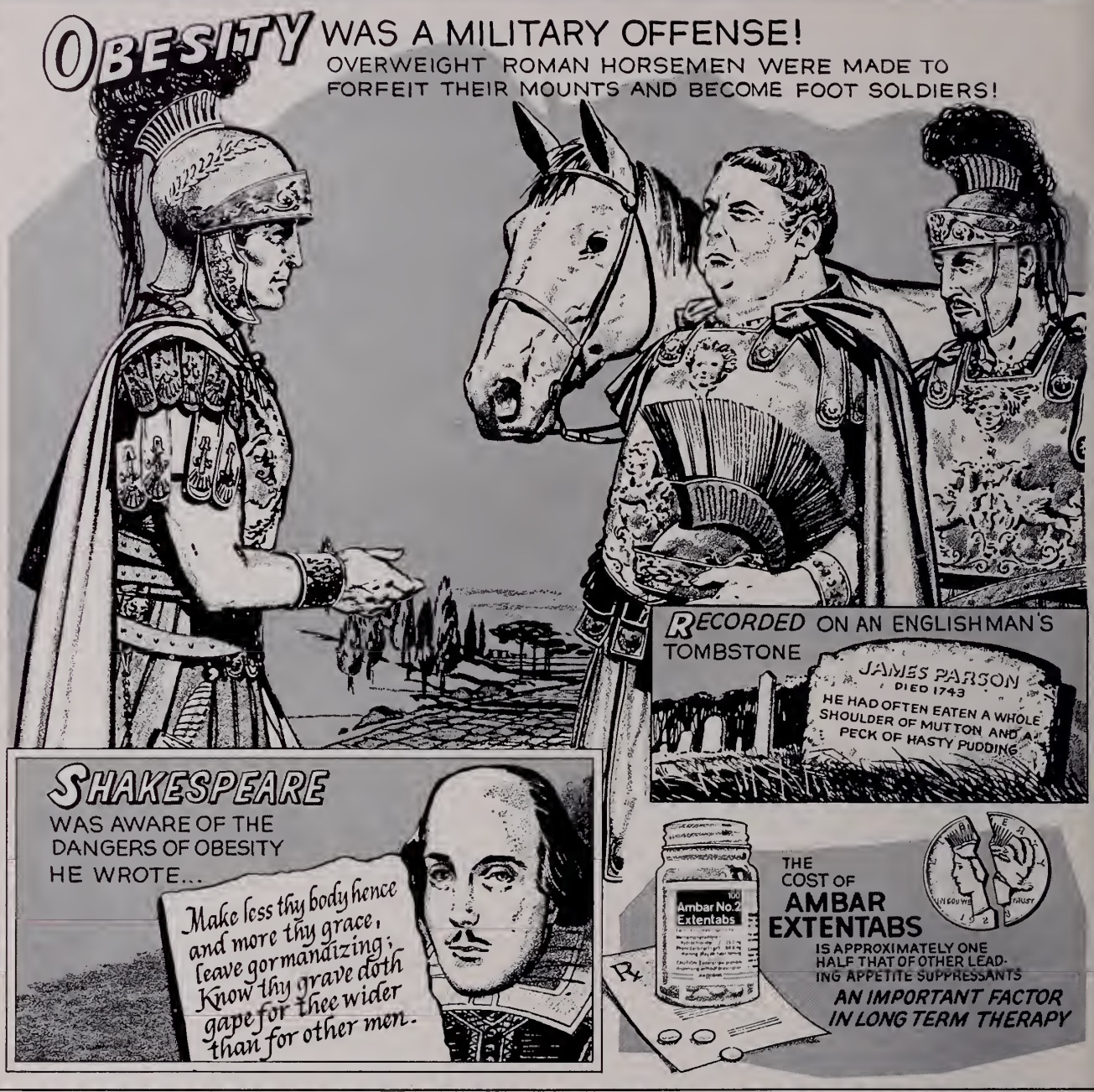
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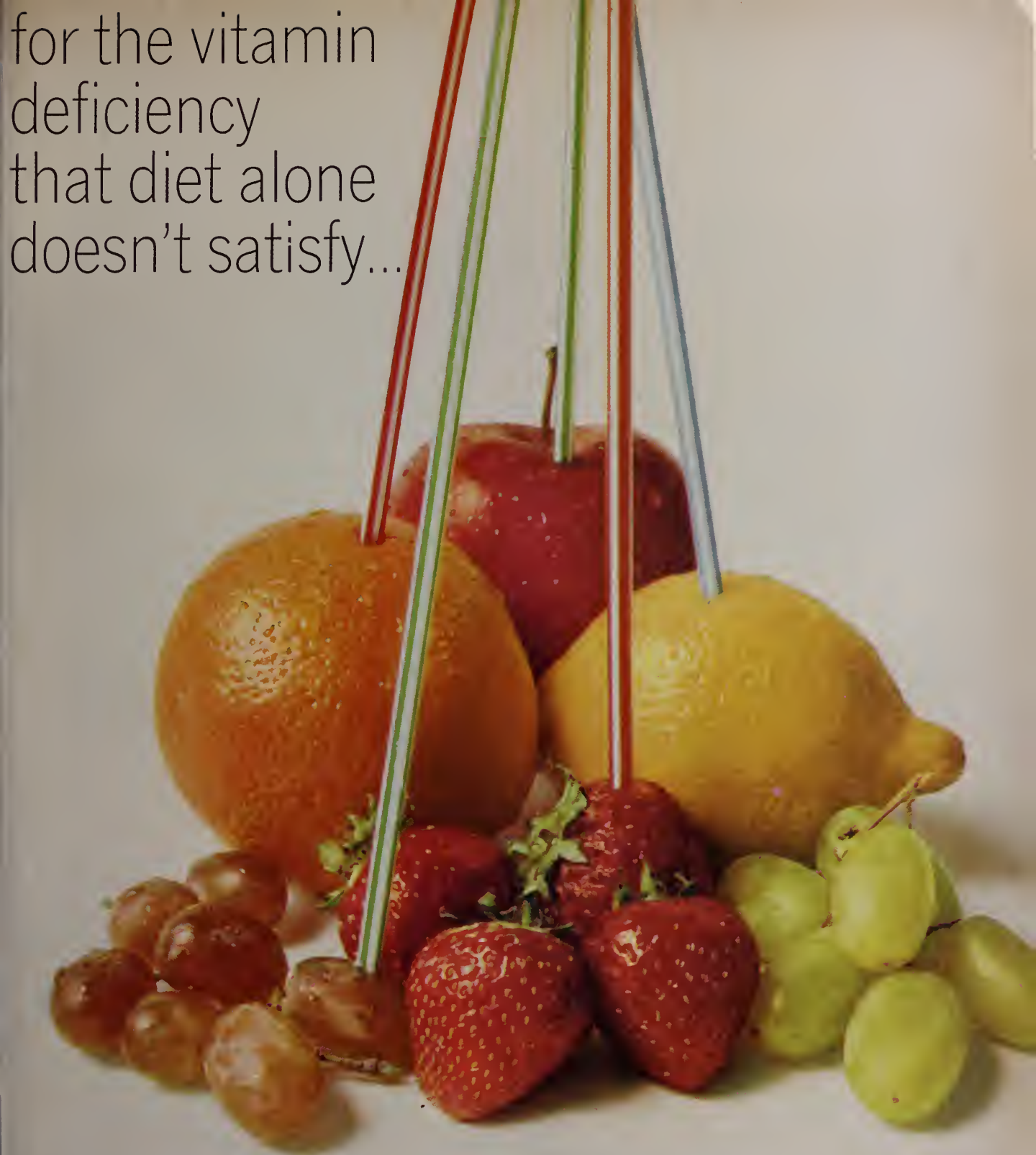
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ORGANIZATION SECTION

AMA House Speaker To Deliver Keynote Address At Opening Session Of 1970 KMA Interim Meeting April 8-9 in Gilbertsville

Russell B. Roth, M.D., speaker of the House of Delegates of the American Medical Association, will be the keynote speaker at the opening session of the 1970 Interim Meeting April 8-9 at Kentucky Dam Village State Park, Gilbertsville.



Doctor Roth



Mr. Koon

A 1939 graduate of Johns Hopkins University of Medicine, Doctor Roth has been very active in the affairs of organized medicine, serving as speaker of the House of Delegates of the Pennsylvania Medical Society from 1962-67, past chairman of the AMA Council on Medical Service and the Federal Medical Services Committee and vice speaker of the AMA House of Delegates from 1967-69. The keynote address, which will follow a dinner on Wednesday evening, April 8, will deal with "Health Care in the 70's".

Thursday morning's program will begin with a panel discussion on Peer Review, moderated by Walter L. Cawood, M.D., Ashland, KMA president. Featured on the panel are John W. Koon, Louisville, executive secretary of the Kentucky Farm Bureau Foundation; Lowell H. Steen, M.D., president of the Indiana State Medical Association, and Marvin A. Bowers, Jr., M.D., Louisville, chairman of the KMA Claims and Utilization Review Committee.

Mr. Koon, who has been with the Farm Bureau since 1949, is a member of the Comprehensive Health Planning Council and will discuss peer review from the consumer's viewpoint. Doctor Steen's topic will be "The Role of the County Society" and Doctor Bowers will present KMA's guidelines on peer review.

Following this discussion will be a panel which will deal with "A Profile of the Physician's Assistant in Kentucky". Walter I. Hume, Jr., M.D., Louisville, will moderate this panel which will discuss the training and utilization of these assistants in the medical profession. The names of the other participants on the panel will be released in the March *Journal.*

J. Ed McConnell, Louisville, president of Kentucky Physicians Mutual, Inc. and Blue Cross Hospital Plan, Inc., will deliver the luncheon address at the close of the meeting on April 9.

A meeting of the KMA Board of Trustees, an Orientation Program for new members and a meeting of the Woman's Auxiliary to KMA will also take place during the Interim Meeting.

Doctor Cawood urges all physicians to make plans now to attend this two-day session and to secure reservations as soon as possible. A reservation form can be found on page 124 for your convenience.

U.L. And Heart Association Plan Annual Symposium March 25-26

The Sixteenth Annual Symposium on Cardiovascular Diseases is scheduled to be held March 25 and 26 at the Stouffer's Louisville Inn. The two-day session is sponsored by the Heart Association of Louisville and Jefferson County, the University of Louisville School of Medicine and the Jefferson County Academy of General Practice.

Featured on the program, which will be acceptable for 11 prescribed hours by the American Academy of General Practice, are a number of nationally known heart specialists.

Noble O. Fowler, M.D., professor of medicine, Cardiac Research Laboratory, Cincinnati General Hospital, will deliver the Bernard D. Rosenblum Memorial Lecture, speaking on "Pericardial Disease".

Included among the guest speakers are Robert G. Schlant, M.D., division of cardiology, Emory University School of Medicine, Atlanta; E. L. Quinn, M.D., division of infectious diseases, Henry Ford Hospital, Detroit; John P. Merrill, M.D., Harvard Medical School, Boston; and Donald E. Oken, Cardiorenal Section, Peter Bent Brigham Hospital, Boston.

Carl Fortune Lecture Highlights Lex. Clinic Conference April 2

Harvey C. Knowles, Jr., M.D., Cincinnati, will deliver the third Carl Fortune Lecture at the Fifteenth Annual Clinical Conference of the Lexington Clinic April 2, according to George R. Park M.D., program chairman.



Doctor Knowles

Doctor Knowles, professor of medicine at the University of Cincinnati College of Medicine, will speak on "The Treatment of Diabetes Mellitus. Medium and Long Term Problems." A 1942 graduate of the Columbia University Medical School, Doctor Knowles is director of the metabolism division of the department of medicine at Cincinnati.

Beginning at 9 a.m. at the Lexington Clinic, the Conference will feature discussion of various medical aspects of Diabetes Mellitus, the program's theme for 1970. Other guest speakers include Sheldon Berger, M.D., professor of medicine, Northwestern University Medical School, Chicago, and John B. Selby, M.D., chief, Nuclear Medical Service, Veterans Administration, Lexington.

Members of the Clinic staff will also take part in the program, which will be acceptable for five hours prescribed credit by the American Academy of General Practice.

1970 KMA Senior Day Program To Be Held in Lexington

The 1970 KMA Senior Day Program will be held Tuesday, April 7, at Continental Inn, Lexington, according to Hoyt D. Gardner, M.D., chairman of the KMA Senior Day Committee. The program, which was completely redesigned last year, will feature a joint session for the senior medical students of both the University of Louisville and the University of Kentucky.

The afternoon session will feature four individual presentations followed by four separate discussion groups. Speakers and their subjects for this portion of the program include "Features of Organized Medicine", Robert C. Long, M.D., Louisville; "Medical Ethics and Courtesies", N. Lewis Bosworth, M.D., Lexington; "Medical Records and Malpractice", Fred L. Goldberg, M.D., Louisville; "Health Care Delivery", Frank J. Groschelle, Frankfort. The overall theme for the program is "The Delivery of Medical Care".

The carefully planned programs are designed to assist the medical students in making the transition from an academic setting to the actual practice of medicine. The 1970 Senior Day marks the seventh annual program for the University of Kentucky and the sixteenth for the University of Louisville.

The evening session of the program will be followed by a social hour and dinner sponsored by the Fayette and Jefferson County Medical Societies.

Doctor Gardner emphasized appreciation of his committee members and the official family of KMA for the cooperation of the two medical schools and the support of the Jefferson and Fayette County Medical Societies in making these programs possible.

Six Ky. Physicians Appointed To AMA Committees, Councils

Six Kentucky physicians recently were appointed or reappointed by the Board of Trustees of the American Medical Association to membership on its councils and committees. The term of service for members of councils and committees of the Board is one year with a maximum tenure of 10 consecutive terms.

J. C. Cantrill, M.D., Georgetown, was appointed to serve on the Committee on Medicine and Religion and Robert Straus, Ph.D., Lexington, was appointed to the Committee on Alcoholism and Drug Dependence.

Reappointments included William T. Rumage, Jr., M.D., Louisville, Council on National Security; William K. Keller, M.D., Louisville, chairman of the Committee on Medical Aspects of Automotive Safety; and David B. Stevens, M.D., Lexington, Committee on Quackery.

Robert W. Lykins, M.D., Louisville, was reappointed to the Interspecialty Committee, American Society of Anesthesiologists.

SMA Section Elects Dr. Schiavone

Robert Schiavone, M.D., Louisville, was recently elected as assistant secretary of the Section on General Practice of the Southern Medical Association. Doctor Schiavone will work with the other newly elected officers in arranging the program for the Section for the 64th Annual Meeting of the Association November 16-19 in Dallas.

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Digest of Board of Trustees Minutes December 11, 1969, Presented

The second meeting of the Board of Trustees was a regular session held at the KMA Headquarters Building on December 11, 1969. Members of the Board expressed their sympathy upon learning of the death of Rex Hayes, M. D., Glasgow, a past vice president of KMA, and past chairman of the Board.

Accepted for information were the President's Report, Headquarters Office Report and Report of Delegates to AMA. A special report was presented concerning the good results of Kentucky physicians at the 1969 AMA Clinical meeting in Denver relating to KMA's promotion of Doctor Robert Long's candidacy for AMA president.

One of the more lengthy items of discussion related to peer review and the recommendations of KMA's Claims and Utilization Review Committee. The mechanism for the operation of reviewing claims at the county and state level was approved and the state committee was expanded by receiving permission to utilize special consultants to be appointed by the Board. It was announced that a part of the 1970 Interim Meeting Program would be on peer review to assist the county societies and advise them of Kentucky's guidelines.

Numerous legislative matters were considered since the Kentucky General Assembly would be in session within a couple of weeks. Specific action was taken on matters concerning the restructuring of the State Board of Health, Medical Licensure, and licensing of interns.

Inquiries had been received concerning the "physician assistant" and other new paramedical categories. A presentation was made on this subject by Joseph Hamburg, M. D., chairman of KMA's Health Careers Committee, at the request of the Board Chairman. The Health Careers Committee was expanded in size, and its duties broadened to "evaluate, assist and bring before the Board any paramedical program that is proposed in this state, and recommend action to the Board. . . ." It was also reported that the physician's assistant will be a subject of panel discussion for the Interim Meeting.

The Chairman of the Legislative Committee for National Affairs, Hoyt Gardner, M. D. announced that the U. S. Senate had just taken favorable action concerning professional corporations, suggested KMA develop a definitive tobacco statement for presentation to the AMA, and reported that the KMA Annual Congressional Dinner in Washington, D. C. would be held on May 26.

A discussion concerning Kentucky's medical schools followed with a recommendation being made that the Legislative Committee consider new concepts for the medical schools in service to the state and in sources of financial assistance.

George Brockman, M. D., chairman of KMA's Comprehensive Health Planning Committee was in attendance to update the members of the Board concerning his study of tuberculosis in Kentucky. Noting certain portions of his committee's report had not been implemented, it was agreed a letter would be written requesting such action.

A lengthy discussion was also held on the subject of optometry and KMA reaffirmed its position on legislation expected to be introduced into the Kentucky General Assembly relating to optometry.

Other action by the Board included the appointment of a special medicine and religion committee for the purpose of establishing seminars this year, and the appointment of a KMA representative to a state Food, Nutrition and Health Study Committee.

Membership was authorized in the Woman's Auxiliary to the Student American Medical Association, and student member dues in the KMA were waived for the 1969-70 Associational year. It was reported that the active membership of KMA had reached an all-time high of 2,411 members.

Appendicitis — Berardi

(Continued from page 106)

Conclusion

A review of appendectomies performed in a small community hospital has been presented. Various aspects pertaining to diagnosis and treatment were discussed. A suggestion is offered to encourage more reporting from community hospitals in order that the true incidence of morbidity and mortality related to the surgical treatment of appendicitis might be better established.

References

1. *PAS Reporter*: The leading causes of admissions, 1965-1967. Vol. 7, No. 5; July 21, 1969.
2. *PAS Reporter*: The 50 most frequent operations, 1967. Vol. 7, No. 6; August 11, 1969.
3. *PAS Reporter*: Death and autopsy rates for 50 leading causes of admission, 1963. Vol. 3, No. 12, February 7, 1966.
4. Cantrell, J.R. and Stafford, E.S.: The diminishing mortality from appendicitis. *Ann. Surg.* 141: 749, 1955.
5. Clements, W., Olson, J.E. and Powers, J.H.: Acute appendicitis in a rural community. *Ann. Surg.* 161: 231, 1965.
6. Ross, F. P., Zarem, H. A. and Morgan, A. P.: Appendicitis in a community hospital. *Arch. Surg.* 85: 1036, 1962.
7. Byrne, J. J.: Advances in diagnosis and treatment of the acute abdomen. *Surg. Cl. N. America.* 39: 1346, 1959.
8. Talbert, J.L. and Zuidema, G.D.: Appendicitis—A reappraisal of an old problem. *Surg. Cl. N. America.* 46: 1101, 1966.
9. Coldrey, E.: Five years of conservative treatment of acute appendicitis. *J. Internat. Coll. Surgeons.* 32: 255, 1959.
10. Longino, L.A., Holder, T. M. and Gross, R. E.: Appendicitis in childhood. A study of 1358 cases. *Pediatrics.* 22: 238, 1958.

M.D.'s Practicing 50 Yrs. Sought

The Fifty Year Club of American Medicine is interested in securing the names of those physicians who have been in practice for 50 years or more. This organization meets annually at the AMA Convention. For information, contact Davis W. Goldstein, M.D., secretary and treasurer, 100 South 14th Street, Fort Smith, Arkansas 72901.

New Social Security Benefits For Self-Employed Physicians

Social security disability benefits can now be paid to an insured person under 65 who has a physical or mental impairment so severe as to keep him from doing any substantial work for a year or longer.

Many self-employed physicians, with their earnings covered since 1965, have now contributed to social security long enough to be insured for disability. Payments begin after a waiting period of six full calendar months.

Self-employed physicians disabled in the immediate future, however, would probably not yet be eligible for these maximums since their earnings have been covered by social security for a relatively short time.

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KENTUCKY MEDICAL ASSOCIATION

INTERIM MEETING, APRIL 8-9, 1970

REQUEST FOR ACCOMMODATIONS RESERVATION

Complete and mail directly to Kentucky Dam Village State Park, Gilbertsville. This reservation is for the night of April 8 ONLY.

☐ Lodge Room-two double beds-$16.00

COTTAGES:

☐ Efficiency-combination living room, bedroom, kitchen and bath-$14.00

☐ Two-bedroom-living room, kitchen, bath-$20.00

☐ Three-bedroom Deluxe-living room, dining area, kitchen, 1½ baths, garage-$22.00

☐ Three-bedroom-living room, kitchmen, bath-$24.00

☐ Three-bedroom Deluxe-living room, dining area, kitchen, 1½ baths, garage-$28.00

☐ Executive-living room, dining area, custom kitchen, 3 bedrooms, 2 baths, color television-$39.00

PAYMENT MUST BE SENT WITH YOUR RESERVATION

NO LATER THAN MARCH 25, 1970

Names of those sharing accommodations:

Name _____

Name _____

Name _____

Address to which Confirmation to Be Sent: _____

Street Address

_____

City State Zip Code

Return reservation request to: Reservation Department, Kentucky Dam Village State Park, Gilbertsville, Ky. 42044, Telephone - 502 - 362-4271.

Note: This reservation is for the Kentucky Medicol Association meeting, April 8-9, 1970

Federal Narcotics Bureau Lists Rules for Physician Protection

The Federal Bureau of Narcotics has prepared 15 "Don'ts for the Practitioner" to protect him from narcotic addicts and abusers.

Don't leave prescription pads around; addicts may be forgers.

Don't write a narcotic prescription in lead pencil, or any prescription at all in pencil as they may be changed to call for morphine.

Don't write narcotics as "Morphine HT ½ # X" "Morphine HT ¼ # 10." Several "X's" or zeroes can be added to raise the amount. Use brackets or spelling.

Don't carry a large stock of narcotics in your bag. Addicts are often watching doctors' offices and cars.

Don't store your office narcotic supply unprotected, especially near a sink or washroom; patients may ask to use these facilities.

Don't fall for a story from a stranger claiming an ailment that usually requires morphine. The addict can produce blood sputum, simulate bad coughs or other symptoms. Make your own diagnosis.

Don't give an Rx to anyone except the actual patient. Addicts have posed as nurses.

Don't write for large quantities of narcotics unless unavoidable. Diversion to addicts is profitable, as much as $1 for ¼ grain M.S.

Don't prescribe narcotics on the story that another physician has been doing so; consult that physician or hospital records.

Don't leave prescriptions signed in blank for nurses to fill in; many have been stolen by addicts.

Don't treat an ambulatory addict. They must be under proper control; many go to several physicians at one time.

Don't dispense narcotics without keeping records, although bedside and office administration is permissable.

Don't buy your office narcotic needs on an Rx blank. The law requires that you use an official order form.

Don't resent a pharmacist's call for verification of a prescription. He is held responsible if forgeries are filled.

Don't hesitate to call an agent of the Federal Bureau of Narcotics (at your nearest Federal Building) or the Narcotics Division of your State Department of Health if the patient is suspect. Your information will be held in strict confidence.

A *Class A Narcotic* Rx should never be phoned in except in true emergencies; even, the pharmacist must have a written prescription in his or his agent's hand before he can make delivery to your patient. Violations of this section of the narcotic law may entail two to 10 years imprisonment and up to a $20,000 fine for the first offense; second and third violations are more severe.

In Memoriam

W. F. CARTER, M.D.
Pleasureville
1880 - 1969

W. F. Carter, M.D., 85 died December 21 in Shelbyville. A 1907 graduate of the Hospital College of Medicine in Louisville, Doctor Carter practiced medicine in Brodhead for 15 years before setting up practice in Pleasureville.

CLAUD W. CHAPPELL, M.D.
Louisville
1908 - 1970

Claud Wilbur Chappell, M.D., 61, died January 2 in Florida while on vacation. A 1934 graduate of the University of Louisville School of Medicine, Doctor Chappell held a degree in pathology, but was a general practitioner. Doctor Chappell was an Army major during World War II.

CLIFTON GEORGE FOLLIS, M.D.
Glasgow
1901 - 1970

Clifton George Follis, M.D., 68, died January 12 in Venice, Florida. A 1927 graduate of the Indiana University School of Medicine, Doctor Follis, a surgeon, had been practicing in Glasgow since 1930.

WINFIELD S. GABHART, M.D.
Harrodsburg
1887-1969

Winfield S. Gabhart, M.D., 82, a practicing physician and surgeon in Harrodsburg for 60 years, died June 11. Death was attributed to a heart attack. A 1910 graduate of the University of Lousville School of Medicine, Doctor Gabhart studied at the Mayo Clinic, Rochester, Minnesota and the Poly Clinic, New York. He was a member of the Mercer County Medical Society and the Kentucky Medical Association.

PSYCHIATRY RESIDENCY

If you have been in practice for five years or more, you are eligible for Psychiatry Residency under a U.S.P.H.S. grant.

If you have been in practice less than that time, you are still eligible.

Dependency allowance.

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Louisville General Hospital
502-589-4321
502-582-2211

WILLIAM ALBERT GRAHAM, M.D.
Flemingsburg
1900-1969

William Albert Graham, M.D., a general practitioner from Flemingsburg, died August 23 at the age of 69. A 1929 graduate of the Medical College of Virginia, Doctor Graham was a member of the Kentucky Medical Association and the American Medical Association.

JAMES A. PAYNE, M.D.
Louisville
1926 - 1969

James A. Payne, M.D., died December 24 at the age of 43. A radiologist at Louisville's St. Anthony Hospital and a teacher at the University of Louisville Medical School, Doctor Payne was a member of the Kentucky and Greater Louisville Radiological societies and the American College of Radiology. Doctor Payne was a 1955 graduate of the University of Louisville Medical School.

BEN WILSON SMOCK, M.D.
Louisville
1894 - 1970

Ben Wilson Smock, M.D., 75, died January 1 in Louisville. A 1918 University of Louisville School of Medicine graduate, Doctor Smock was active in the affairs of organized medicine. A former KMA vice president in 1924 and former president of the Jefferson County Medical Society, Doctor Smock practiced medicine on horseback in Muhlenburg County before returning to Louisville in 1924, where he practiced until his retirement in 1955.

Freedman Lectures Planned

Jerome Shapiro, M.D., director, department of radiology, Boston City Hospital, Boston, will deliver the 22nd Annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology. The Lectures will be held April 18-19 at the University of Cincinnati College of Medicine.

KMA Committee Reports

Senior Day Program Committee
Hoyt D. Gardner, M.D., Louisville, Chairman

KMA Headquarters Office **November 20, 1969**

The KMA Senior Day Program Committee met recently to outline plans for the 1970 Senior Day Program to be held in Lexington on April 7. Representatives of both Fayette and Jefferson County Medical Societies were present and discussion centered on ways by which the program could be made more attractive to the senior medical students.

The committee followed the program format which was designed last year, which will again bring the seniors of both schools together in a joint session.

Sponsored by KMA, this year's presentation will be the 16th Annual Senior Day for the University of Louisville and the 7th Annual Program for the University of Kentucky.

Hospital Committee
James B. Holloway, Jr., M.D., Chairman

KMA Headquarters Office **December 4, 1969**

At the recent meeting of the KMA Hospital Committee, a great deal of discussion centered on new methods of implementing effective hospital utilization review committees. A recommendation was sent to the KMA Board of Trustees which provides for a subcommittee of the Hospital Committee to be established to set up a demonstration program in conjunction with Region 15 of the Comprehensive Health Planning Council.

Other items on the agenda included a review of the newly published *Proposed Revisions of Standards for Accreditation of Hospitals* and a discussion of the low utilization of Kentucky's hospital based extended care facilities.

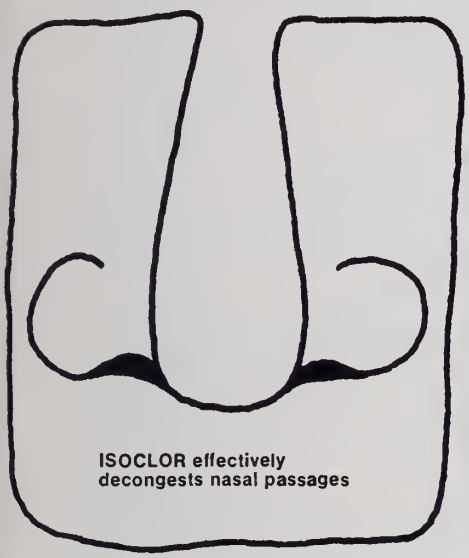
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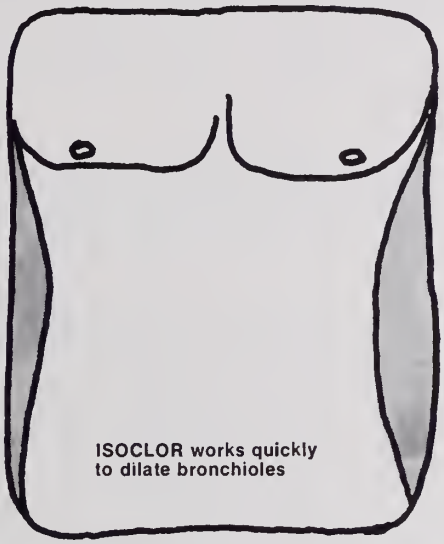
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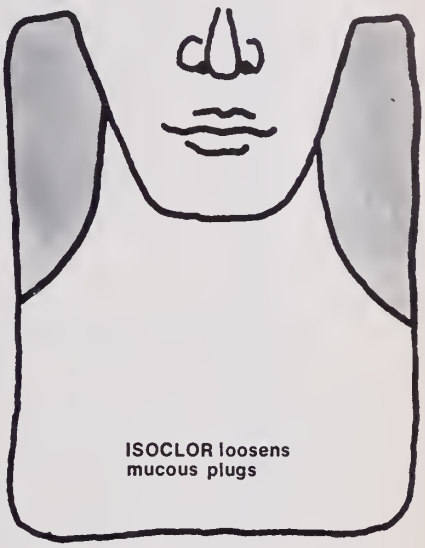
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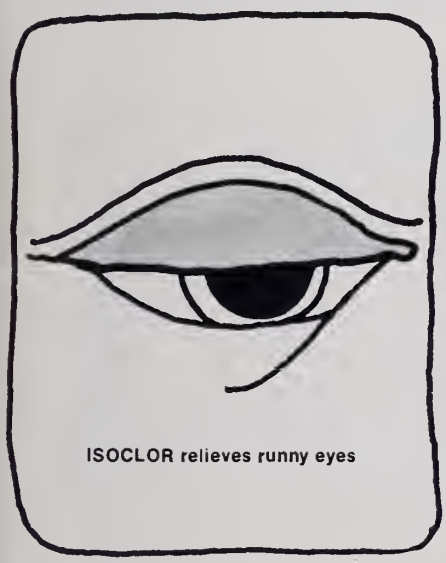
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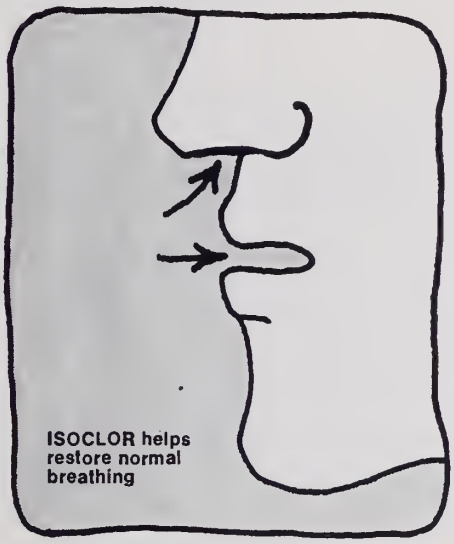
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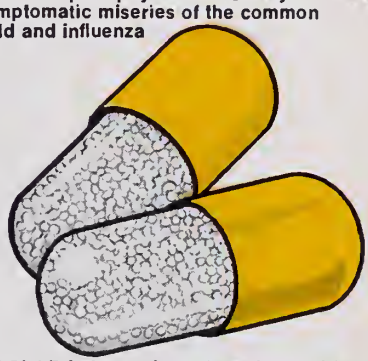


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Isoclor provides quick, long lasting relief of respiratory congestion and discomfort brought on by common colds, influenza, and allergies. Isoclor contains chlorpheniramine maleate — one of the most potent and safest antihistamines. And pseudoephedrine HCl — a decongestant bronchodilator providing effective and long lasting relief for the entire respiratory tract. Both work to extend the range of relief.

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Chlorpheniramine Maleate.....4 mg.
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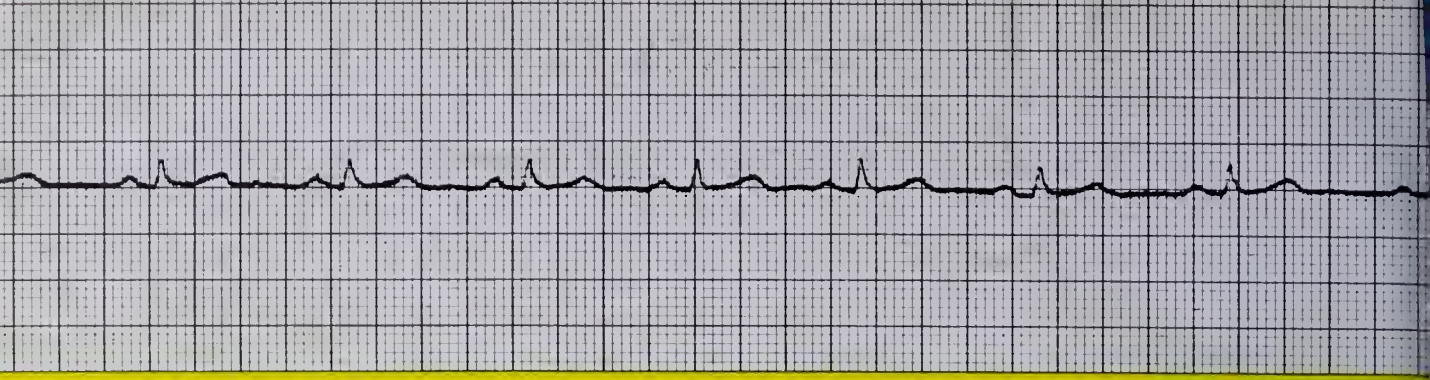
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

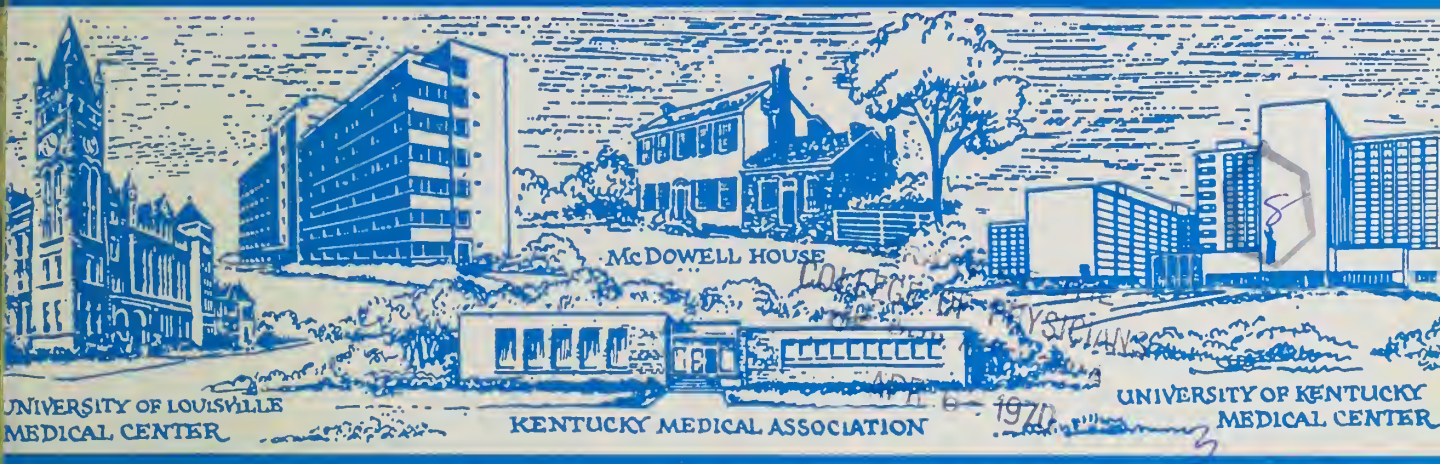
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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VOLUME 68 MARCH 1970 NUMBER 3

The Journal of The KENTUCKY Medical Association



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KMA INTERIM MEETING
April 8-9
Kentucky Dam Village State Park—Gilbertsville

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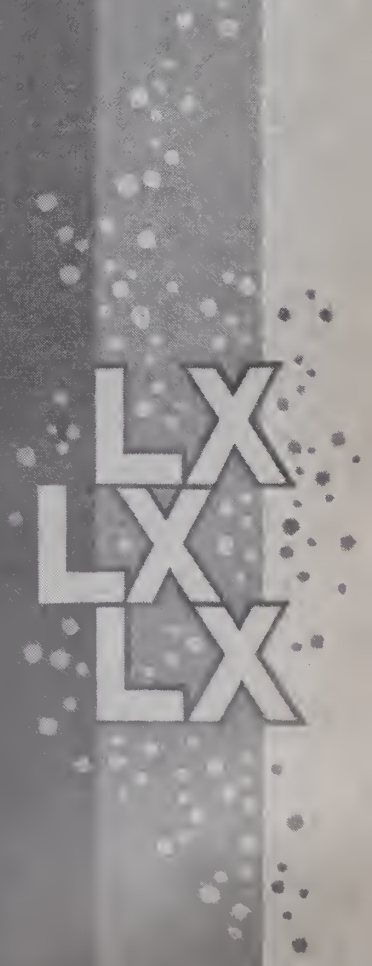
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References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

Volume 68 • March 1970

Issued Monthly Under the Direction of the Board of Trustees

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Loulsville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

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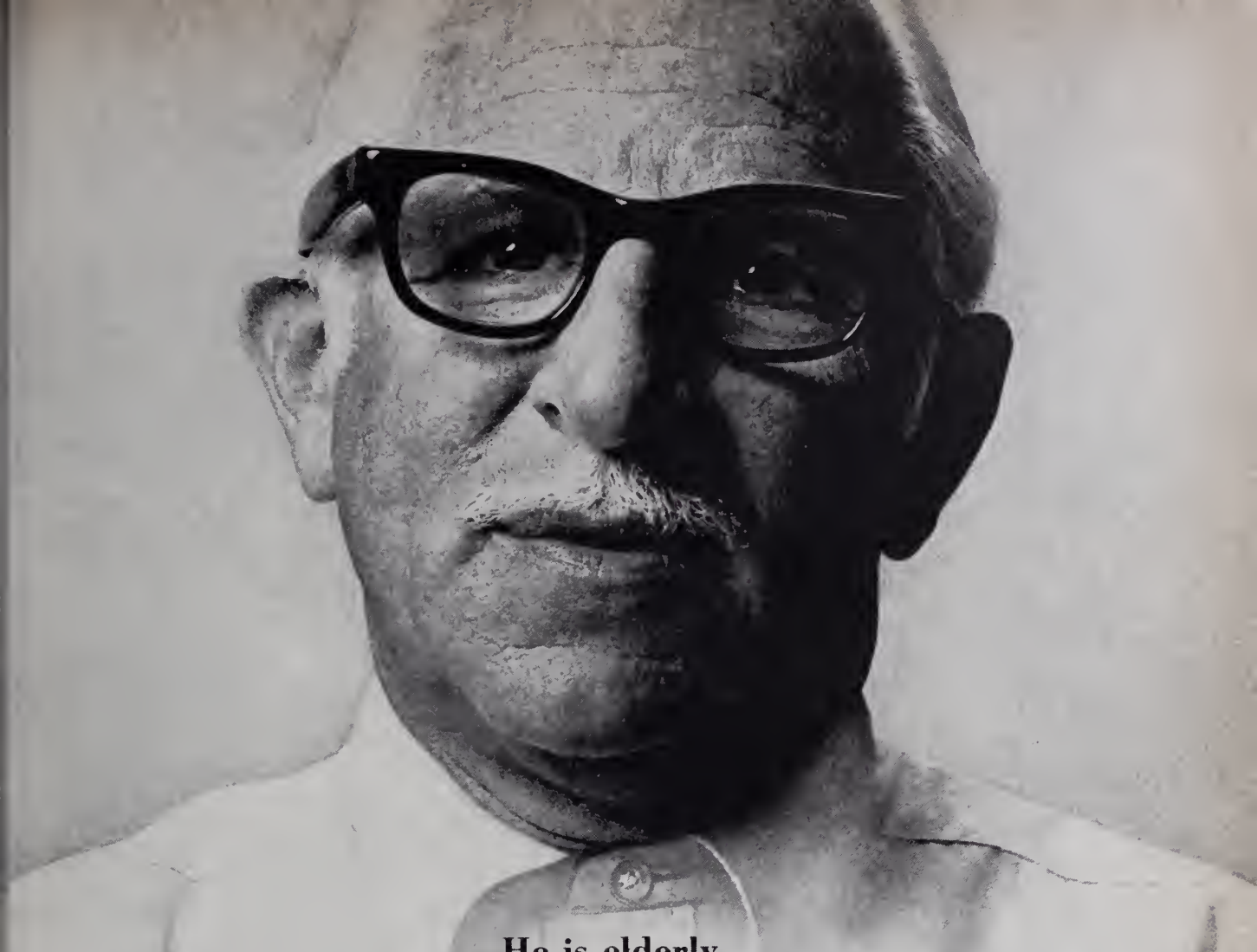
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MESSAGE FROM THE PRESIDENT



Kentucky Medicine In The 1970's*

IT became obvious in the 60's that medicine is undergoing a revolutionary change which will affect the decade of the 70's.

Never before has there been such a widespread criticism of and resentment against the health care industry. Problems related to the ever accelerating cost, availability of quality health care, provision of prepayment mechanisms, and the professional facilities and equipment shortages are but a few of the items to be faced by medicine in the 70's.

The public has laid the increased cost of medical care at the feet of the physician and has mistakenly lumped professional medical care with all health care costs. It is felt that through utilization and claims review, the professional cost of medical care can be controlled but private insurance companies and our own Blue Cross-Blue Shield must be the leaders in the field of the overall health cost control.

Quality health care must be available to more and more people as pointed out by the youth of today. The premise that "health care is a God-given right" is taken as fact by health planners and politicians. The demand for a National Health Insurance program grows and such disparate interests as the AMA and the United Auto Workers have endorsed the concept. Whatever the end product, National Health Insurance in the 70's appears to be a certainty and it seems now only a matter of deciding how to pay for it.

The role of Kentucky Medicine in the 70's will be discussed at the Interim Meeting at Kentucky Dam Village State Park on April 8 and 9, with Russell B. Roth, M.D., Speaker of the AMA House of Delegates and Mr. J. Ed McConnell, president of Kentucky Blue Cross-Blue Shield as two of the principal speakers.

You are urged to attend.

DAVID A. HULL, M.D.
KMA VICE-PRESIDENT

This is the third in a series of articles written at the request of KMA President Walter L. Cawood, M.D.

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 5-68. This 31-year-old, married, white, gravida III, para II, had an E.D.C. of July 13, 1968. She gained 20 pounds, was RH positive, VDRL nonreactive. Two previous children were born nine and eight years ago, weighing 6 pounds, 15 ounces, and 6 pounds, 9 ounces at birth.

She was admitted to the hospital at 6:45 a.m. June 18, 1968, with a history of vaginal bleeding. Vaginal examination revealed the membranes intact, cervix dilated two cm., blood pressure 104/74. At 8:15 a.m. she had a large amount of bright red vaginal bleeding. Her blood pressure was 110/80 and pulse was 100. Fetal heart was 174. Blood count on admission revealed a hemoglobin of 13 grams, hematocrit 40 per cent. She was observed closely. She had some further vaginal bleeding, but not of a significant amount.

The following morning she was re-examined vaginally and the cervix was thinning. She had no more bleeding. She had the onset of regular contractions the morning of the 19th and was medicated at 10:45 a.m. with 50 mgs meperidine HCl intravenously. At 11:15 she had 25 mgs promethazine HCl intramuscularly, and another 50 mgs meperidine HCl intravenously at 1:30. At this time she was 4 cm. dilated and cervix was thin, membranes were bulging, fetal heart was good. She was found to be completely dilated at 2:00 p.m. and was taken to the delivery room. Saddle block anesthesia was given. The membranes were ruptured artifically and she delivered a 6 pound 9 ounce boy without episiotomy. The placenta separated intact, spontaneously, and examination revealed some recent and old organized clots. The cause of the bleeding was thought to be a marginal sinus rupture, since no palpable placenta had been felt on previous examinations or in labor. The blood loss was estimated between 250 to 300 cc. The cervix was checked, there were no lacerations. The uterus was not explored, and the patient was watched in the delivery room.

Post-partum, temperature was normal. The following day, the 20th, patient was up, went to shower, voided, temperature was normal. Around 9:30 a.m. on the 22nd of June, patient complained of a severe headache and blindness. She screamed and had a seizure. Her pupils were constricted. Her respirations were shallow, blood pressure 120/80, pulse 54. Her physician was called. She had no verbal response to comment or stimuli. Her pupils then were observed to be quite dilated, pulse was 80, respirations shallow and irregular. Her respirations ceased at 10:33. She received positive pressure oxygen. A neurologist was consulted, and the patient was transferred to the intensive care unit. The neurologist's findings were that of an unresponsive individual, pupils were widely dilated, fixed to light; extremities were flaccid, no obtainable reflexes. Her blood pressure fluctuated from 180/100 to 90/60, her pulse was strong and regular.

The impression was ruptured aneurysm of the basilar artery, posterior cerebral connection. Treatment consisted of maintaining an airway, fluid administration and control of blood pressure. Portable chest X-ray demonstrated early congestive failure. Skull X-ray revealed the sella turcica, normal. EKG was read as atrial tachycardia. Serum Electrolytes were obtained, and sodium, potassium, chloride and CO_2 were normal. The patient continued to show no improvement. Tracheostomy was performed, however, she continued to merely exist under the controlled breathing, and expired at 9:03 a.m. on June 27, 1968.

An autopsy was obtained and positive findings were as follows:

From the area of the base of the brain stem, extending laterally to the parietal area, coagulated blood was found—40 cc involved the area of the cerebellum. The cerebellum lost its usual architecture and was a semi-solid state, failing to show the gyrations or markings of pressure. The brain stem was in a semi-solid state and cerebellum markedly softened; the gyri are flat, sulci, shallow, with no appreciable deviation in the brain. The brain was markedly softened, spinal cord displayed area of red discoloration. On the right side 1 mm below the origin of the posterior cerebellar artery, there was a 2 x 2 mm ruptured aneurysm in the basilar artery. The uterus and cervix were normal. No abnormalities were present.

Final Diagnosis:

(1) Basilar artery ruptured aneurysmal hemorrhage.
(2) Massive uecrosis of the pons.
(3) Massive necrosis of the cerebellum.
(4) Massive encephalopathy of the cerebrum.
(5) Edema of spinal cord.
(6) Pneumonia, bilateral.

Comment

This maternal death was classified by the Committee as an indirect obstetrical death with no preventable factors. This was a hopeless situation. According to various authorities, ruptured aneurysms of the basilar artery are extremely lethal[1, 2]. Because of her stuporous condition and decerebrate signs, this patient

was not a candidate for surgery. The life history of a ruptured aneurysm is bleak, whether or not pregnancy is present. According to Drake[1], although it may be possible to shut off the neck of the sac of a basilar aneurysm there is extreme danger to the patient from retraction on the temporal lobe and injury to the group of important tiny perforating vessels which are hidden behind the aneurysm will occur. It is his feeling that these aneurysms should be operated only after careful consideration of the risk to the patient. He concludes by saying that it might be wise to restrict operation to those bifurcation aneurysms where the sac is small and projects forward and has a good neck.

Intracranial hemorrhage has been found to be a more common cause of maternal death than was previously believed[3]. In a series by Barnes and Abbott[4] among 176 maternal deaths, 36 were caused by cerebral complications. Seventeen of the 36 were the result of intracranial hemorrhage. Eastman[3] quotes the Minnesota mortality statistics during the decade 1950 to 1959, the number of deaths of pregnant women from cerebral hemorrhage was approximate to that from cardiac disease. The obstetric problem concerns the management and delivery in the minority of the women who survive these catastrophes. Current opinion would favor Cesarean section for delivery when the diagnosis has been made. Certain authors[3, 5] indicate that when cerebral hemorrhage occurs shortly before or early in pregnancy, therapeutic abortion is indicated.

References

1. Drake, C.G.: Surgical Treatment of Ruptured Aneurysms of the Basilar Artery. *J. Neurosurgery* 23:457, 1965.

2. Griffen, W.O., Jr., Dilts, P.V., Jr., and Roddick, J.W., Jr.: Non-Obstetric Surgery During Pregnancy. *Current Problems in Surgery* Year Book Medical Publications. Chicago, November 1969.

3. Eastman, N.J., and Hellman, L.M., Williams, *Obstetrics*, Thirteenth Edition, Appleton-Century-Crofts, New York, Page 776.

4 Barnes, J.L., and Abbott, K.H.: Cerebral Complications Increased During Pregnancy and the Puerperium. *California Med.* 91:237, 1959.

5. Gomberg, B.: Spontaneous Subarachnoid Hemorrhage in Pregnancy not Complicated by Toxemia. *Am. J. Obst. & Gynec.* 77:430, 1959.

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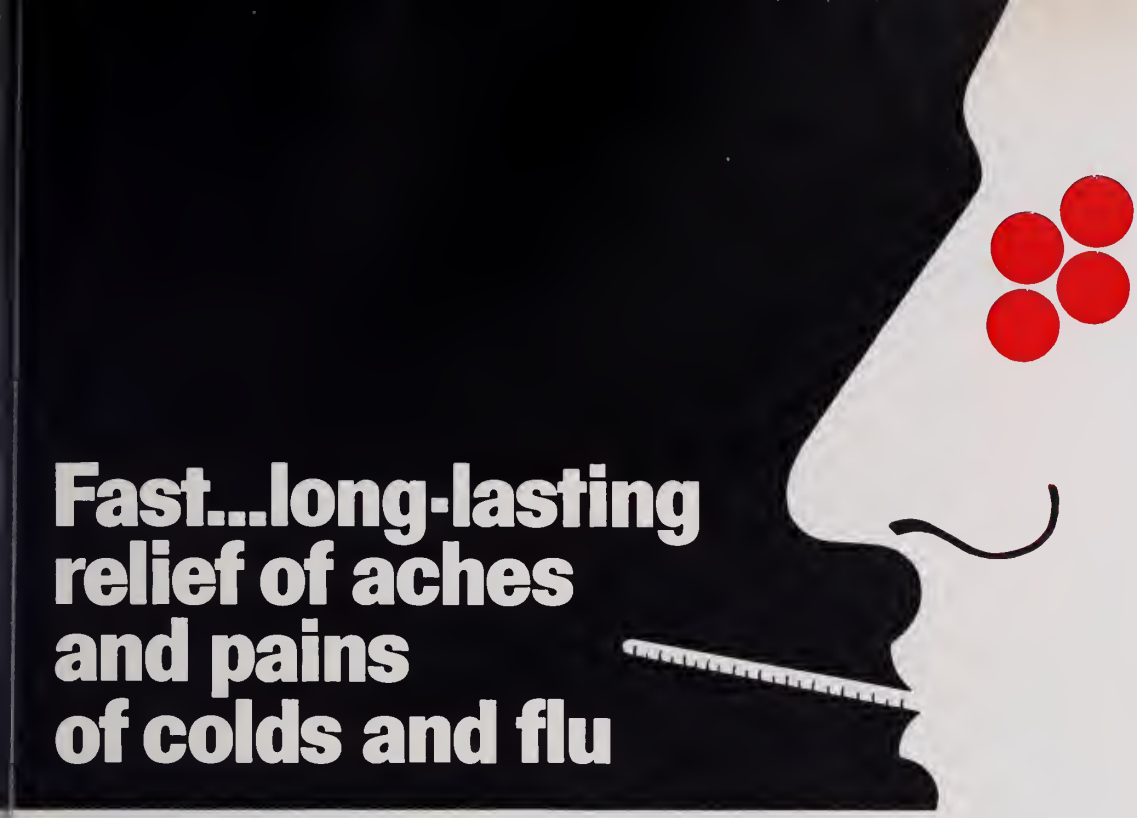
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In 1215, at Runnymede, under threat of Civil War, the barons and clergy forced King John to sign the Magna Charta. All peoples in the English speaking tradition still cherish the liberties granted by the Magna Charta. Among other freedoms was "Judgement by His Peers". The English word "peer" in this case comes from the Latin *par*, which means, "equal."

Today, we take judgement by our peers to be granted, yet some physicians have been a little reluctant to establish peer review committees. The delay seems to have been unusually long. When third parties are paying medical fees, it is inevitable that someone will review charges and medical records. If it is not a local peer review committee, it will be a statewide peer review committee, which will not be familiar with local standards and customs, and if not this, review may be by "Appointed Officials, or Foreign Mercenaries".

All County Medical Societies of appropriate size are encouraged to form local peer review committees to facilitate disputed third party claims.

LEWIS DICKINSON, M.D.

Don't Miss The Panel Discussion

on

PEER REVIEW

at the

KMA Interim Meeting

Kentucky Dam Village State Park — April 8 and 9



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The JOURNAL of the
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The Story of Intussusception in an Area of 750,000 People†

Bernard J. Schoo, M.D.

Louisville, Kentucky

Intussusception occurs in older children and the mortality rate is high when all cases from a large community are compared to published statistics from large pediatric centers.

THE purpose of this paper is to compare the statistics of intussusception as handled by all the hospitals in a large community with those recorded in the literature from major pediatric centers where a preponderance of infants and younger children are managed. The literature is very consistent and emphasizes that 80-90 per cent of these patients are under two years of age, 10-12 per cent have an anatomic abnormality and the mortality rate has decreased to one to three per cent[1, 2, 3, 4, 5, 6]. More and more authors are recommending diagnosis and treatment by barium enema with a 40-60 per cent cure and no mortality[1, 2, 3, 5].

Material

This is a review of the proved cases of childhood intussusception from all the hospitals in the metropolitan area of Louisville from July 1, 1953 to July 1, 1969. The population of this area is 750,000. The records of 160 patients were obtained from record rooms, x-ray department, surgery departments and pathology departments.

†*Presented at the Kentucky Chapter, American College of Surgeons meeting in Louisville, Kentucky, September 25, 1969*

Etiology and Types

The etiologic pathology in this series conforms to the expected. There were 10 Meckel's diverticula, four small bowel polyps, two duplications and two lymphomas, which together comprised 11 per cent of the entire group. One of these patients with a Meckel's diverticulum died. (TABLE I)

TABLE I

ETIOLOGY IN 160 PATIENTS

Meckel's Diverticulum	10
Ileal Polyp	4
Duplication of Ileum	2
Lymphosarcoma	2

The types of intussusception were classified for simplicity into 13 small bowel (8.1 per cent), 145 ileo-colic (90.6 per cent), and two colo-colic (1.3 per cent) and this conforms to the expected. One small bowel intussusception and seven of the ileo-colic intussusceptions died. (TABLE II)

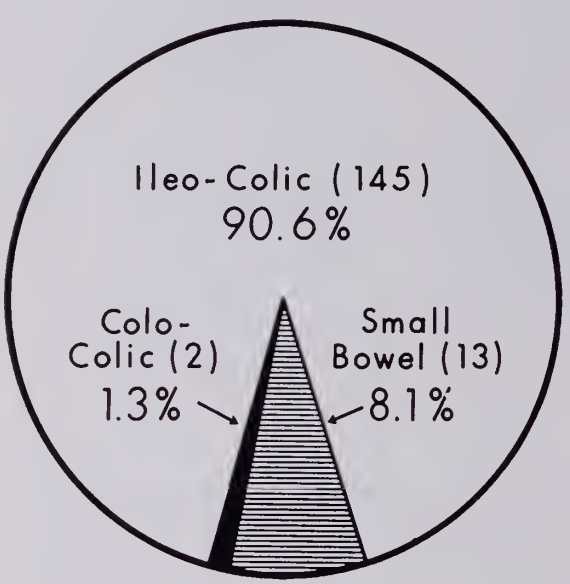
The seasonal incidence is as expected and requires no further comment. (TABLE III)

The greatest variation from the expected was the age incidence. (TABLE IV) This is probably because pediatric hospitals attract the very young infant with abdominal pain but an older child is operated upon in any community hospital. In this series 41 per cent were older than two years and this is the highest per cent of any series I have encountered. This might be due to the fact that cases were included from every community hospital, many of which admit no infants. This difference in expected age is emphasized

so the clinician will not eliminate the diagnosis on the basis of age alone.

TABLE II

TYPES OF INTUSSUSCEPTION



Clinical Manifestations

The chief complaint of pain and/or vomiting did not vary from the expected, but the fact that a mass was palpated in the abdomen of only 48 per cent of the cases is far below other reported series of 75-85 per cent[3, 6]. (TABLE V) Blood was present in the stool in only 43 per cent of these cases as compared to twice that usually recorded. This should mean that these cases are being diagnosed and treated sooner than average but the fact that a mean of 43 hours elapsed before treatment in this group belies this suggestion. Forty-three hours is slightly longer than other series report but this is a very ambiguous and difficult statistic to gather. In this series it is the time estimated to be the vague onset of symptoms to the time anesthesia was begun or the intussusception reduced in x-ray. As most authors stress and this report indicates, it is a rare patient who dies if treatment is begun in less than 24 hours from the onset of the symptoms.

Barium enema was done in 71 per cent of these cases and 21 per cent were successfully cured. (TABLE VI) No case could be found where it was thought that the x-ray department contributed to a mortality. It is known in this locale that the roentgenologists have not attempted to reduce intussusception with vigor and yet 30 per cent of all patients receiving barium enema had the intussusception reduced. Many centers advocating this method of treatment report 40-50 per cent cure without surgery[1, 2, 5]. The only contraindication is based on the severity and not the duration of the child's illness. It is my belief that a barium enema should be done immediately for an attempted cure in all cases except the extremely ill. The technique of the barium enema is recorded in other articles[5, 6].

Treatment

Surgery was performed on 138 of these patients, of which 34 or 25 per cent had a bowel resection for either a pathologic entity or jeopardized bowel. (TABLE VII) Two additional patients were not operated upon and died in less than 18 hours after admission to the hospital.

It might be well to mention a few interesting patients. Two had recurrence weeks later after reduction by barium enema, one due to a Meckel's diverticulum and the other had no known etiology. This latter patient had two reductions by barium enema and later a reduction and appendectomy and still later a fourth intussusception reduced by surgery. One patient had an ileo-colic intussusception extending to the anus. One patient had a Swenson pull-through procedure and seven days later had a small bowel intussusception surgically

TABLE III

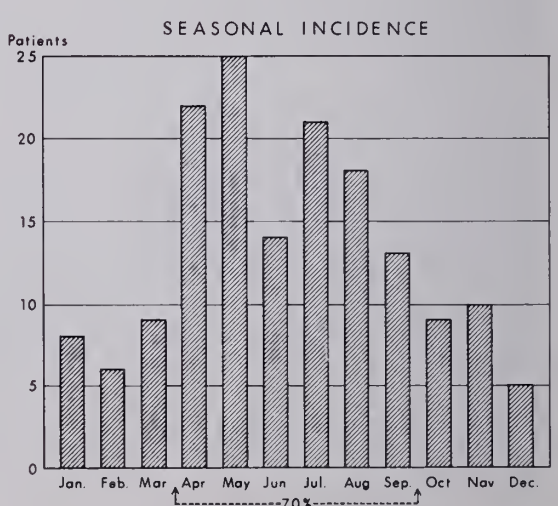
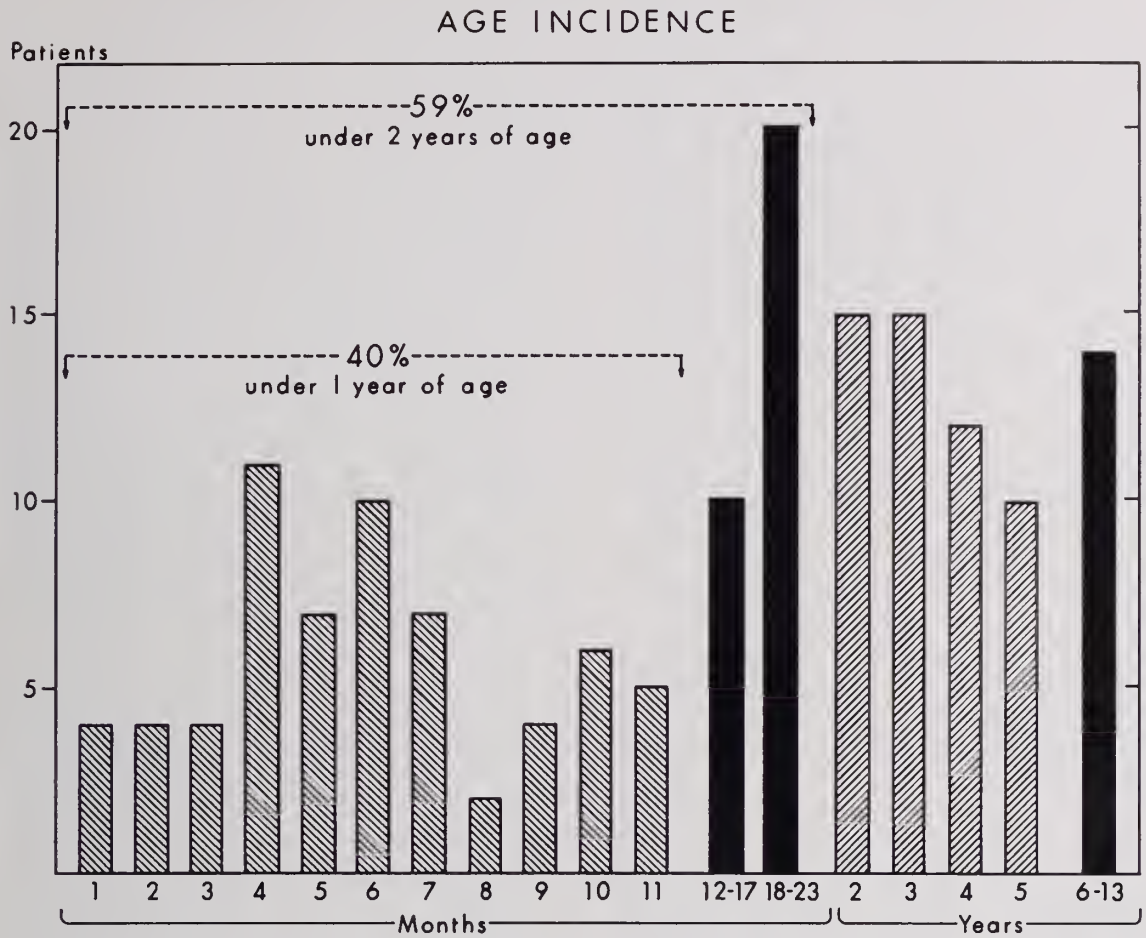


TABLE IV



corrected. One patient had an ilco-colic intussusception reduced surgically and a milk bezoar removed from the stomach incidentally.

TABLE V

CLINICAL MANIFESTATIONS

Chief Complaint—Pain	69%
Palpable Mass	48%
Blood in Stool	43%
WBC Below 12000	58%
Definite Etiology	11%
Hours Before DX	43
Days in Hospital	6.2
Mortality (8)	5%

Mortality

The overall mortality rate is five per cent and the treatment mortality is three per cent. (TABLE VIII) It is important to note that all deaths except one had a bowel resection, all except one had a bloody stool and all except one had symptoms longer than 24 hours. This last patient (G) had a normal barium enema but an upper G. I. series showed a "coil spring" in the small bowel. He had a necrotic retrograde intussusception of the mid small bowel resected, followed by a suture line leak, multiple fistulae and death many procedures and months later. He was the only patient to receive an upper G. I. series and the only retrograde intussusception. A larger resection or a different anastomosis might have saved his life. Case C was admitted at eight days of age for diarrhea and vomiting. He remained in poor condition for 36 days and then two days prior to surgery had bloody stools and vomited again. A barium enema proved the intussusception. He was given blood and electrolytes. Necrotic bowel was resected and he died the same day. Case D was difficult to analyze and it may be presumptuous to assume that he died of overhydration. An ileo-colic intussusception was reduced and a Meckel's diverticulum and appendix removed. He received "100 ccs. of fluids/lb. next 24 hours" as ordered until he died 72 hours later. Better post-operative care may have saved his life. Case E was an error

in diagnosis. An appendectomy was done on the day of admission (the pathology report was "normal appendix") and his symptoms persisted. Two days later an exploratory laparotomy revealed a necrotic ileo-ileal intussusception which was resected and he died two days later. Careful exploration at the first surgery may have saved his life. Case F had diarrhea and vomiting for five days and a fever of 103. He was taken to surgery almost immediately in poor condition and died one hour later in the recovery room. Better preoperative care may have saved his life.

TABLE VI

X-RAY DATA	PATIENTS	PER CENT
Diagnosis by BA Enema	114	71
BA Enema Not Done	46	29
Reduced in X-Ray—No Surg.	22	14
Reduced in X-Ray—Surgery	12	7.5
Not reduced by BA Enema	81	50

TABLE VII

TREATMENT OF 160 PATIENTS

Reduced by BA Enema—No Surgery	22
Reduced in Surgery—Appendectomy	71
Reduced in Surgery—No Appendectomy	18
Found reduced—Appendectomy	16
Bowel Resection	34
No Surgery	2

Discussion

In conclusion a few facts were obtained from this series which might be helpful. Surgical technique, pre-operative and post-operative care were believed the cause of four deaths. Symptoms longer than 24 hours or bloody stools or patients requiring bowel resections all denote a high mortality. The WBC is of no significance. Many patients were admitted with other suspected diagnosis such as appendicitis, vomiting, diarrhea, meningitis or abdominal pain which delayed the correct diagnosis and treatment. Some patients were hospitalized, sent home and readmitted a day or two later which increased their morbidity and hospital stay. It is to be remembered that intussusception occurs commonly over two years of age. A diagnosis should be made as quickly as possible by a barium enema at any time during the day or night. With proper technique this alone should cure nearly half of the patients. Considering that this group of patients was operated on at a variety of community hospitals by a variety of general surgeons, a mortality rate of three per cent is better than anticipated but certainly should be improved.

Summary

All cases of intussusception from a metropolitan area of 750,000 people are reviewed and compared to other series from pediatric centers. The deaths are discussed in detail. Treatment with barium enema is advocated as the safest and simplest with the least morbidity and mortality.

Acknowledgements

The author wishes to express his appreciation to the authorities of the following hospitals from which this material was collected:

Children's Hospital, Louisville
Jewish Hospital, Louisville
Kentucky Baptist Hospital, Louisville
Louisville General Hospital, Louisville
Methodist-Evangelical Hospital, Louisville
Norton Memorial Infirmary, Louisville
Pewee Valley Hospital, Pewee Valley
Red Cross Hospital, Louisville
St. Anthony Hospital, Louisville
St. Joseph Infirmary, Louisville
SS. Mary and Elizabeth Hospital, Louisville
Clark County Memorial Hospital, Jeffersonville, Indiana
Floyd County Memorial Hospital, New Albany, Indiana
St. Edward's Hospital, New Albany, Indiana

TABLE VIII

DEATHS

Case	Age	Chief Complaint	Mass	Temp	Bled	WBC	Cond On Adm	Length Of Symp	Hosp Days	BA Enema	Surgery
A	2 Mo.	Diarrhea	Yes	100	Yes	7700	Term	3 days	1	No	Bowel Resect
B	5 Mo.	Vomiting	No	101.6	Yes	8100	Term	3 days	¾	No	None-Autopsy
C	6 Wk.	Diarrhea	No	99	Yes	10400	Poor	2 days	38	Yes	Bowel Resect
D	6 Mo.	Vomiting	No	101	Yes	8300	Good	2 days	4	Yes	Bowel Resect
E	3 Yr.	Pain	Yes	99	No	9050	Good	1 day	5	No	Bowel Resect
F	4 Mo.	Diarrhea	No	103	Yes	9700	Poor	5 days	6 hr	Yes	Reduction alone
G	11 Mo.	Pain	No	99	Yes	7500	Good	12 hrs	150	No	Bowel Resect
H	10 Mo.	Vomiting	No	100	Yes	None	Term	1 day	12 hr	No	None-Autopsy

(*Continued on page 182*)

Polymorphous Eruption with Arthritis

Ullin W. Leavell, M.D.*, J. William Hollingsworth, M.D.** and Louis D. Dubilier, M.D.***

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A 17-year-old white female has been studied whose problem was characterized by 14 different cutaneous lesions, arthritis, stomatitis and elevated temperature. We feel that this new syndrome is best called polymorphous eruption with arthritis.

THE purpose of this report is to describe a patient with an unusual, possibly unique combination of skin lesions associated with proliferative arthritis. The term polymorphous eruption was chosen 1) to define this disorder because no one other expression could characterize the many different cutaneous lesions which developed; and 2) to distinguish it from other disease entities. During the period of observation, approximately 20 different skin lesions developed and some manifested a peculiar response to steroid therapy in the form of deep ulcers. The latter most closely resembled pyoderma gangrenosum but differed in that there were many lesions of other varieties as well as many mucous membrane lesions, and they apparently constituted a response to steroid therapy. The associated arthritis could not be classified as rheumatoid or any other classic type.

Report of a Case

The patient was a 17-year-old white female who entered the University of Kentucky Medical Center one year after the onset of an itching eruption which started as small blisters on her arms and legs and was associated with bilateral knee pain. Subsequently, the rash spread to involve her entire skin surface and the joint pain affected her wrists, fingers, elbows, ankles and feet. Six months prior to admission, she was hospitalized for "septicemia" and was treated with penicillin for 11 days. During the four months prior to admission, she was treated with Erythrocin and Kantrex capsules. She became bedridden two weeks prior to hospitalization because of weakness, joint pain and draining skin lesions. She had lost 28 lbs. of weight and developed severe dental caries during the one year illness. Sixteen months prior to admission she had delivered a normal, healthy infant. There was no history of an abnormality of any other body system.

Physical examination revealed a well-developed, thin female with normal vital signs who was continuously scratching her arms and legs. Hundreds of red papules (FIG. 1a) varying between two and three mm. in diameter, were present over the skin of the torso and upper and lower extremities. Six tender, red, cutaneous nodules (FIG. 1b), varying between two and four cm. in diameter, were seen on the legs, feet, sacrum and iliac crest. Her fingers, wrists, elbows, knees and ankles showed marked arthritis with effusions, erythema, tenderness and "doughy" thickening of periarticular tissues (FIG. 2f). Extensive dental caries were present (FIG. 2e). The remainder of the physical examination was within normal limits.

Laboratory data included a hemoglobin of 12.3 gms. per 100 cc., hematocrit of 35 per cent, and a white blood cell count of 5,400 per cubic milliliter with a normal differential. Urinalysis and blood cultures were negative. Serum electrolytes, protein concentration, and serum electrophoresis were within normal limits as were fasting blood sugar, bromide and iodide concentrations, antistreptolysin-O titer, and latex test for rheumatoid factor. No cryoglobulins were identified. Throat culture, darkfield examination of ulcers, stool examination for ova and parasites, and tuberculin and histoplasma skin tests were negative. Culture of the skin lesions yielded coagulase positive Staphylococcus aureus and Pseudomonas aeruginosa, both of which were sensitive to

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penicillin, erythromycin, and chloramphenicol. Anaerobic cultures were negative. Roentgenographic examination of the chest, intestinal tract, and joints was negative.

Course

During the first month after admission the patient continued to have intense pruritus followed within two or three hours by a papular and vesicular cutaneous eruption for which saline compresses were applied. The papules were erythematous and varied between two and three mm. in diameter; they were distributed over the torso, arms and legs. The vesicles were of two types. Eight to 10 clear, two to three mm. vesicles on non-erythematous bases (FIG. 1e) were distributed over the sides of the fingers and torso. Ten to 15 similarly sized hemorrhagic vesicles, from which serosanguineous material could be obtained by puncture were located around the fingernails and toenails.

A variety of other lesions developed during the latter part of the month. These included 4 purple bullae (FIG. 1f), 1.5 to 2.0 cm. in diameter, over the dorsal aspect of the toes; about 10 similar sized papulosquamous lesions (FIG. 1a) scattered over the torso; eight annular lesions, about two cm. in diameter, with clear centers and erythematous peripheries over the abdomen and back; four similar sized bulls-eye lesions (FIG. 1b) with dark purple centers surrounded by erythematous rings over the thighs; five smaller erythematous target lesions (FIG. 1a) with dark purple centers over the torso; 15 to 20 purpuric lesions (FIG. 1d), measuring 0.3 to 1.0 cm. in diameter, over the feet and legs. On the feet, lower third of the legs, sacrum and iliac crest were six erythematous slightly elevated nodules of 2.0 to 3.0 cm. in size (FIG. 1b), some of which contained several sinuses from which pus and serosanguineous material exuded.

During the fourth week after admission, the eruption spread rapidly to involve her scalp and more than 100 excoriated one to two mm. papules (FIG. 1c) developed. At the same time she developed about 25 painful superficial three to four mm. buccal ulcers (FIG. 2e) covered with a gray exudate, a sore, red, tender tongue with elevated papillae, a low grade fever up to 101° F., and a leukocytosis of 33,000 white blood cells per cu. mm. The cutaneous lesions continued to form and she was started on Deltasone tablets, 15 mg., four times daily.

Within two days after beginning the steroid therapy, there was a reduction of the pruritus and within seven to 10 days, the hundreds of smaller lesions healed, leaving atrophic, depigmented areas surrounded by hyperpigmented borders (FIG. 2d). Some healed lesions left irregular depressed scars. The original nodules followed a different course after steroids. Within 24 hours they developed a bluish red border measuring 5 to 8 mm. in width (FIG. 2a). Within three days the centers of these lesions became black and gangrenous (FIG. 2b). The central zones then shrunk and separated from the surrounding skin in

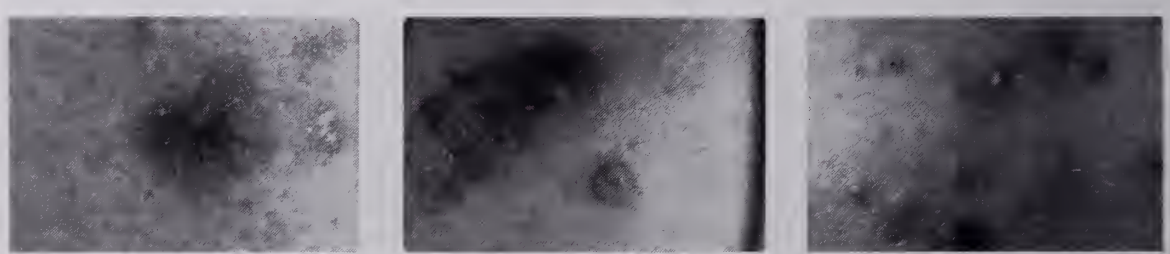


FIG. 1 (a) Papules, papulosquamous and target lesion. (b) Large nodule with draining sinuses and target lesion. (c) Multiple nodules, vesicles and excoriated papules.

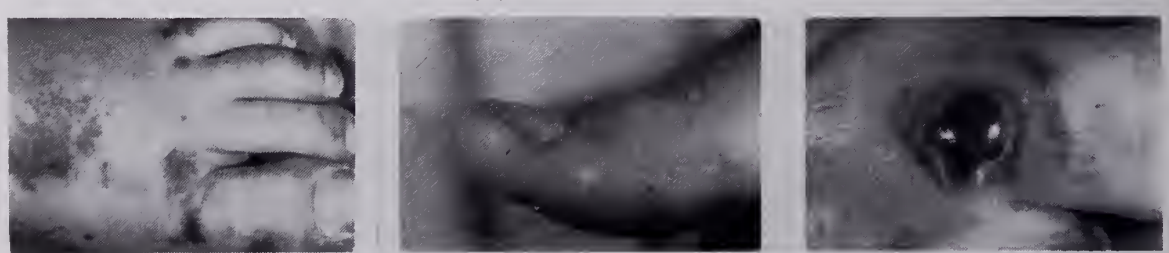


FIG. 1 (d) Pupuric lesions. (e) Clear vesicles on nonerythematous base. (f) Hemorrhagic bulla, 1.5 cm. in diameter. Figures 1a-f were taken prior to steroid therapy.

approximately 10 days, leaving ulcers with rolled borders and serosanguineous fluid exuding from their bases. Three weeks after the start of Deltasone therapy, the ulcers became deeper with tendons visible in the base of the ulcer on the dorsum of the right foot and muscle in the ulcer (FIG. 2c) on the right calf. These ulcers were extremely tender, being sensitive even to air.

Six weeks after beginning steroid therapy, zinc peroxide suspension was applied to the ulcers daily, the dental caries were treated and the patient was begun on sulfapyridine, 0.5 mg., four times a day. The ulcer on the right foot began to heal within four days, granulation tissue being evident at its base. In approximately three months, all the ulcers healed progressively and the skin returned to a nearly normal condition.

Histopathology

Biopsies from several different types of skin lesions taken before the institution of Prednisone therapy demonstrated variable histopathologic changes.

A vesicular lesion demonstrated a subcorneal vesicle containing blood and acantholytic cells, spongiosis and slight disorganization of papillary dermis with scattered polymorphonuclear leukocytes which also involved the wall of contained capillaries. Another vesicle was essentially similar to this but exhibited more acute inflammatory exudate (FIGS. 3 & 4).

A pearly papule demonstrated similar but irregular subcorneal clefts with marked polymorphonuclear exudate forming a cone-shaped area with the base toward the skin surface. Included in this area were thrombi in some small vessels (Chart 1).

Two nodules demonstrated hyperkeratosis, focal parakeratosis, irregular acanthosis and patchy subepidermal cleavage. The superficial dermis abutting the epidermis showed chronic inflammation with lymphocytes and a prominent histiocytic response associated with multinucleated cells containing blue and red curled fibers which stained as elastic tissue with special stains. There appeared to be a greater concentration of inflammatory cells about small vessels (FIG. 5). The deeper dermis and subcutis were unremarkable.

A papulosquamous lesion from the toe demonstrated a layer of parakeratosis deep to which a loose keratin layer showed some cleavage. Beneath this was a prominent granular cell layer and slight acanthosis, irregular slight papillomatosis, and slight perivascular chronic inflammation.

Results

It was difficult to determine whether there was any consistent natural progression of lesions from one stage to another. The primary lesions appeared to be either pruritic erythematous papules or vesicles which progressed to bullous, papulosquamous or bulls-eye lesions

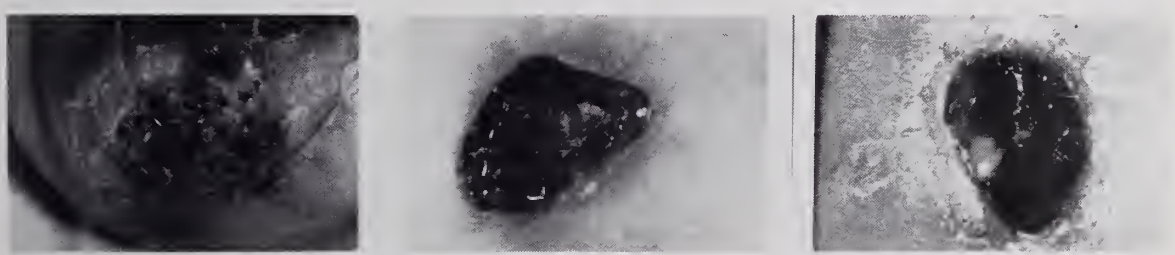


FIG. 2 (a) Purple border developing around nodule. (b) Gangrenous plug surrounded by moat filled with serosanguineous fluid. (c) Ulcer with underlying muscle visible. Zinc peroxide suspension surrounds the lesion.



FIG. 2 (d) Small scar with atrophic center and hyperpigmented border. Figures 2a-d were taken following steroid therapy. Note many small healed lesions in Figure 2d. Large ulcers, however, increased in size during time patient was on steroids. (e) Many small ulcers, 0.2 to 0.4 cm. in diameter, over mucous membrane to lower lip. (f) Swelling of interphalangeal joints, erythematous macules over hand.

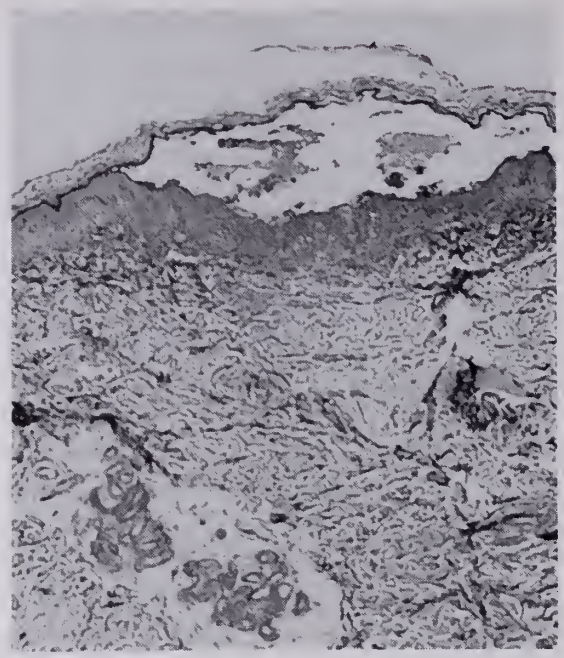


FIG. 3 Phatamicrograph af a vesicle showing subcarneal cleavage and containing proteinaceaus fluid and exudate. Nate subepidermal acute inflammatian. (Hematoxylin and Eosin x160)

in several days, nodules in about 10 days, and draining sinuses in about 14 days. The pathologic counterparts of some of these various lesions in their earliest phases were subcorneal and subepidermal vesicles with an associated variable dermalepidermal neutrophilic exudate. The later phases were characterized by a superficial dermal granulomatous response with very prominent elastic tissue phagocytosis. None of these lesions ulcerated naturally. After the inception of steroid therapy, many of the smaller lesions healed rapidly leaving scars with depigmented centers and pigmented borders. Only the nodules followed a clinical course in some ways similar to pyoderma gangrenosum with the development of bluish red borders followed rapidly by central necrosis and the formation of deep ulcers (Chart 1).

These progressively deepened despitc steroid therapy. Only after the local application of zinc peroxide suspension, sulfapyridine ingestion and care of the dental caries did the ulcers slowly heal.

Discussion

The wide variety of skin lesions in this patient and their association with mucous membrane lesions and proliferative arthritis appears to be different from any we could find described in the literature. Many diseases were involved in the differential diagnosis. Reiter's syndrome was considered because of the combination of arthritis and papulosquamous skin lesions, but since the illness was of one year's duration, included a multitude of other skin lesions, and was not associated with conjunctivitis, urethritis, or colitis, this diagnosis was rejected.

The possibility of rheumatoid arthritis with cutaneous manifestations was thought unlikely notwithstanding the reports of O'Quinn et al.[1] who described purpura, ulceration and gangrene, and of Ayres and Ayres[2] and Perry and Brunsting[3] who described pyoderma gangrenosum associated with rheumatoid arthritis. The failure to demonstrate the rheumatoid factor and the absence of roentgenographic evidence of joint disease one year after the onset of arthritic manifestations support this conclusion.

Multicentric reticulohistiocytosis with its characteristic joint and skin involvement was another consideration, but because of the great variety of other types of skin lesions, it, too, was ruled out. The possibility of the entire spectrum of skin lesions being due to a vasculitis was also considered. Since many slides and many different lesions studied in detail microscopically did not reveal a definite vasculitis, this was also considered unlikely.

Some of the cutaneous lesions closely re-

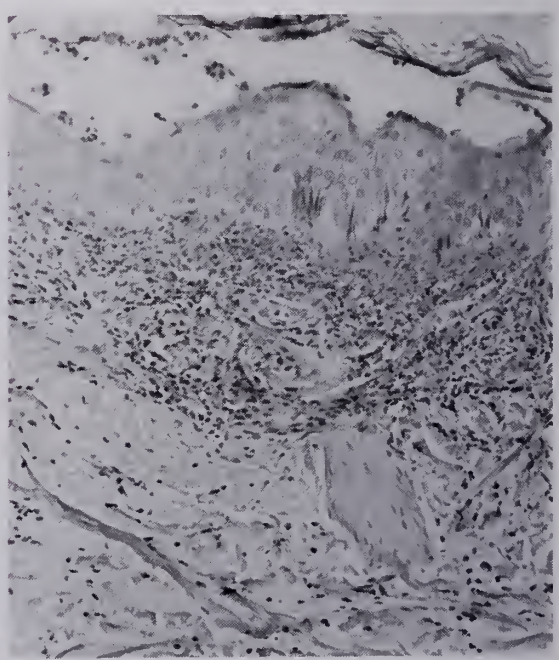


FIG. 4 Phatamicrograph of vesicle shawing slight subcarneal cleavage and praminent neutraphilic exudate in superficial dermis extending into epidermis. (Hematoxylin and Eosin x160)

sembled pyoderma gangrenosum in which an innocent looking pustule enlarges to become centrally necrotic within 24 hours. This plug of necrotic tissue then entends and leaves a deep painful ulcer surrounded by a bluish-red halo. Although some of the lesions did appear to be pustules with blue borders, the ulcers developed only after steroid therapy and did not seem to be related to the natural course of the disease. Ayres and Ayres[2], Perry and Brunsting[3], Keil[5], and Long and Useu[6] reporting on pyoderma gangrenosum, noted grouped vesicles resembling dermatitis herpetiformis on erythematous bases. Ayres and Ayres[2] described the presence of microscopic subepidermal vesicles in this disease. In our case, the vesicles differed from those reported in pyoderma gangrenosum in that they were not grouped, they arose on a nonerythematous base, they were subcorneal, and they contained acantholytic cells.

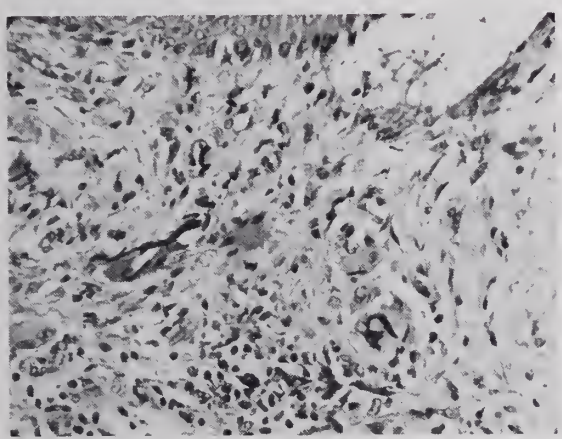


FIG. 5 Photomicrograph of late lesion showing subepidermal vesicle and superficial dermal granulomatous inflammation with prominent elastic tissue phagocytosis. (Elastic-van Gieson stain x400)

Erythema multiforme was considered unlikely because it usually subsides in three to four weeks. It was difficult to determine whether there was any consistent natural progression of lesions from one stage to another. The primary lesions appeared to be either pruritic erythematous papules or vesicles which progressed to bullous, papulosquamous or bulls-eye lesions in several days, nodules in about 10 days, and draining sinuses in about 14 days.

The pathologic counterparts of some of these various lesions in their earliest phases were subcorneal and subepidermal vesicles with an associated variable dermal-epidermal neutrophilic exudate. The later phases were characterized by a superficial dermal granulomatous response with very prominent elastic tissue phagocytosis. None of these lesions ulcerated naturally.

CHART 1

Features of Polymorphous Eruption with Arthritis

A. Clinical.
1. Pruritus and fever.
2. Generalized progressive development of erythema, papules, vesicles, bullae, papulosquamous lesions, annular and target and bulls-eye lesions, nodules, draining sinuses.
3. Consecutive development of arthritis.
4. Oral mucous membrane lesions.
5. Development of deep gangrenous ulcers from nodules and healing of other lesions, including arthritis, following steroid therapy.
6. Slow healing of ulcers following zinc peroxide application, sulfapyridine administration and dental repair.

B. Pathologic.
Early (fewer than 7 days).
1. Subcorneal vesicles with acantholytic cells.
2. Subepidermal vesicles.
3. Patchy parakeratosis and hyperkeratosis.
4. Subepidermal and intraepidermal acute inflammation of variable degree.

Late (more than 7 days).
5. Subepidermal granulomatous inflammation with elastic tissue in macrophages and giant cells.

After the inception of steroid therapy, many of the smaller lesions healed rapidly leaving scars with depigmented centers and pigmented borders. Only the nodules followed a clinical course in some ways similar to pyoderma gangrenosum with the development of bluish-red borders followed rapidly by central necrosis and the formation of deep ulcers (Chart 1). These progressively deepened despite steroid therapy. Only after the local application of zinc peroxide suspension, sulfapyridine ingestion, and care of the dental caries did the ulcers slowly and progressively heal. The selection of this mode of therapy was basically empirical.

Zinc peroxide suspension was used because Meleney and Johnson[7] found it to be of value in cutaneous ulcers from which anaerobic organisms had been cultured. The patient was treated with sulfapyridine since the disease at some stages resembled dermatitis herpetiformis. Her carious teeth were filled and she was instructed in dental hygiene because of the possibility that they were the source of infection in the origin of her disease.

Based on the unusual combination of clinical and pathologic features, we believe this young woman had an inflammatory disease of obscure etiology which would best be named descriptively—polymorphous eruption with arthritis.

(Continued on page 179)

Health Screening on An International Basis

John C. Duffy, M.D.*

A program of periodic examinations utilizing automated laboratory analysis and computer storage of information is described. The capabilities of disease detection in such a system are discussed on the basis of data already obtained.

MOST physicians endorse the concept of the periodic examination for individuals who are apparently well, and there are many publications which enumerate the diagnoses resulting from such examinations. The question may be asked as to the economic value of such examinations. One study demonstrated long-term reduction in insurance costs for individuals who participate in such examination programs.[1] The conclusions might be questioned on the basis of the self-selective process of participants as opposed to non-participants. However, this study is indicative of the potential value of preventive health care.

Before entering into a program of periodic examinations, we believed it necessary to demonstrate that examinations would be productive in disease detection for our population group. We also felt it necessary to determine the acceptance by employees of examinations performed in our medical departments. Therefore, in 1966 we offered to middle management employees at our Corporate Headquarters participation in a health examination program. The employees were selected by the criteria that they were over age 40 and had not been seen in the medical department within the previous year. We felt that this would be the most sensitive employee group and represented those who have the economic means to obtain medical care and who have the intellectual capabilities to recognize the value of preventive health care. Four hundred and twenty employees were invited to participate, of which 351 took advantage of the offer, a participation rate of over 83 per cent. Ninety employees (25 per cent) had undiagnosed findings of significance.[2]

Having completed the pilot study, we faced the question of the type of examination. Should it be the conventional patient-physician examination or a form of screening examination which might be offered to employees. We had several considerations. First, we wished our employees to establish a relationship with a personal physician. Second, if we were to embark upon an examination program with a conventional approach, it would require securing the services of a significant number of physicians to perform these examinations and we did not believe it right to put further stress upon the already limited professional resources in the communities.

Therefore, we observed in some detail the screening examination programs which were operational in California[3] and those which were supported by the Government. We concluded that this approach was acceptable to employees, it was productive in the detection of disease, it had the potential of maintaining the relationship with the personal physician, and the procedures required for the examination could be performed by nurses and technicans.

The Program

For these reasons, we initiated an intensive development effort and in September, 1968, initiated the Voluntary Health Screening Examination Program in the United States and Canada. This program is completely voluntary, it is described to employees as a screening program and not a substitute for a complete examination. It is offered to those age 41 and over. The examinations are performed in 35 of the 38 company locations in the United States and Canada and through the services of physicians retained on a fee-for-service basis where we do not have a large enough employee concentration to support our own medical department. All information is processed at one location, the Medical Data

†*Presented at the annual meeting of the Kentucky Industrial Medical Association, September 25, 1969, Louisville*

**Medical director, IBM Corporation, Armonk, New York*

Center. This center has the analytical chemistry laboratory and the computer support required for the screening examination program.

The examination consists of a self-administered questionnaire, a medical data sheet on which the nurse or technician records specific observations, an electrocardiogram, a chest X-ray and blood chemistries.

A monthly Personnel Data System computer tape reel is received at the Medical Data Center. The tape contains the names, home addresses, work locations and employee identification numbers of all employees in the United States. A similar tape reel arrives each month from Canada. The Personnel Data System tape feeds the employee eligibility data into the computer. Here a selection is made of those employees eligible for participation in the following month by virtue of age and month of birth. The computer prints out eligibility lists for each of the medical departments. At the same time, the computer prepares punched cards with each eligible employee's name and employee identification number printed on them for use in recording the results of his X-ray, electrocardiogram and blood test examinations. These eligibility lists and examination test cards are then mailed to the various medical locations.

A secretary in a medical department prepares the letters inviting all eligible employees to take a health screening examination. An employee receives his invitation letter and descriptive brochure at his work station. If he wishes to participate in the program, he calls the medical department and makes an appointment. If he prefers not to participate, he does nothing. Employees who cannot get to the medical department conveniently will receive a letter signed by the nearest Regional Medical Director telling them they are eligible for the program and inviting them to take their health screening examination at the office of a physician who has agreed to participate in this program.

The Examination

After the employee has decided to take the health examination and has made an appointment, he then comes to the medical department, having fasted for five hours. The participant is given a health questionnaire which is a multipage form containing 167 "Yes"—"No" questions. Certain measurements such as height, weight and blood pressure are completed. A micro-hematocrit test is performed. A venous blood sample is taken for analysis, centrifuged and the serum is decanted into a plastic tube for later shipment.

The employee next receives a standard 14″ x 17″ chest X-ray. A urinalysis is done for specific gravity, sugar and albumin. The employee is given a color perception test for discrimination between red and green. A commercial screening device is then used to check far and near vision both with and without glasses. While the employee is going through the test procedures, the nurse is observing his general appearance including hands, skin, posture and speech, which she records on the Medical Data Sheet. The ear canels are inspected, and then an audiometer examination is performed at 500 to 6000 frequencies at five decibel levels. The employee receives an electrocardiogram using equipment that records the analog signals of the electrocardiogram on tape. The screening examination is now complete, and the nurse reviews the health questionnaire with the employee, obtains detailed information on all "Yes" responses and fills in any unanswered questions.

Data Compiled

All the employee's examination materials are assembled. This material consists of the Medical Data Sheet and the health questionnaire, X-ray film with employee card attached, tube of blood serum with employee's Automated Chemistry Card attached, an electrocardiogram tape reel containing the ECGs of one or more employees and the transmittal sheet listing everything in the container. These materials are then packed in a specially designed container for shipment to the Medical Data Center.

Upon receipt at the Data Center, the container is unpacked and the items are logged in, beginning with the blood sample, which is immediately placed in a refrigerator. The blood serum is analyzed in an automated laboratory. Before analysis, the serum is visually examined for discrepancies, such as the presence of red blood cells. The condition of the serum is noted on the employee's Automated Chemistry Card attached to the tube. Any discrep-

ancies are later punched into a card which feeds information about the discrepancy into the system. The serum tubes are placed in Auto-Analyzers. The Sampler Reader interprets the employee's identification number on the stub of each participant's card and transmits the information to a Data Acquisition Control unit which stores it for later transmission to the Printing Card Punch. The mixture of blood serum and reagent is next moved into a colorimeter which tests the content by passing a beam of light through the mixture to measure its opacity. The reading for each analysis is transmitted to individual wall recorders which permit visual monitoring of the results for each analysis. At the same time, the information is automatically passing a Data Control unit which stores it under the employee's identification number for later transmission to the Printing Card Punch.

While one system is analyzing half of the participants blood serum for cholesterol at the rate of 40 samples per hour, a larger system is analyzing the other half for six factors: uric acid, glucose, urea, bilirubin, SGOT and LDH at the rate of 60 samples per hour. As the Data Control unit receives the results of the six tests performed on the employee's blood serum, it automatically actuates the Printing Card Punch which punches the data into cards for later conversion into magnetic tape for use on the computer. This system also prints out a Confidential Quality Control Report listing the results of the day's work. This report alerts the chemist to any gross drifts from the standard of the chemical reagents the automated analyzer equipment uses in analyzing serum samples. If such a malfunction has occurred, the samples are reanalyzed.

The chest X-ray is interpreted by a radiologist who also notes the technical quality of the X-ray and marks his findings on a special card for later processing.

The reel of ECGs is placed on a Computer Interface which feeds the data to a Data Acquisition and Control System that converts it from analog to digital form. The computer also can reconstitute electrocardiograms using the information on the tape. When the day's electrocardiograms have been processed, the resulting data is used to produce an ECG Analysis Summary. Employee electrocardiograms also arrive at the Medical Data Center as conventional paper recordings taken by participating physicians. These records are interpreted by the cardiologist who marks his findings on a card. If the electrocardiogram information has been stored in the memory of the computer and interpretation by the cardiologist is desired, then a Plotter can reconstitute a paper recording.

The daily output of electrocardiogram and chemistry results are reviewed. If any acute medical situation seems possible, the responsible medical department is advised by telephone. Immediate contact with the employee can be made by the local medical department.

The employee's medical questionnaire and the medical data sheets are fed into an Optical Mark Page Reader device which converts the data into punched cards. These in turn are fed into a Card Read Punch that reads the data into the computer.

The Data Acquisition and Control System now contains all the day's randomly received data on the results of each employee's health examination including blood serum, X-ray, ECG, health questionnaire and the nurse's Medical Data Sheet.

All this health information is analyzed by another computer, and a printout of the results of the screening examination in the form of personal employee medical reports is obtained. The computer records employee health screening data on disc packs everyday which are part of a Direct Access Storage unit.

The medical reports for each medical department are packed and mailed along with their accompanying Medical Disposition Card, X-rays, ECG charts, Medical Data Sheets and electrocardiogram tapes wiped clean for reuse.

The nurse then reviews the employee's medical report with a physician and then she discusses the results with the employee. If a medical problem has been unearthed, the physician will discuss it with the employee and recommend that he seek treatment from his family doctor. The Voluntary Health Screening Examination Program test results and source documents are placed in the employee's confidential file at the medical department.

Results

The results from each examination are recorded on the Disposition Card. This card provides for the recording of diagnosis using

the numeric codes of International Classification of Diseases, Adapted. This information is returned to the Medical Data Center and entered into the computer file with the employee's examination information.

Review of 17,455 records show 48 per cent of the participants, or 8402 employees, identified under the International Classification of Diseases, Adapted. There were a total of 14,181 codes reported on these employees. This indicates a significant number of employees with more than one condition.

During this preliminary phase of analysis of information, we have directed our attention to the cardiovascular system, recognizing such disease produces a high incidence of disability among employees in this age group of our population. Review of the circulatory system revealed that there were 2186 employees reported to have 2720 diagnoses in this classification. Thirty-seven per cent of the diagnoses were hypertension and 24 per cent were listed as ischemic heart disease. Other forms of heart disease accounted for 20 per cent of the diagnoses and 16 per cent were diseases of the veins or other circulatory classifications. Of the diagnoses of hypertension, 20 per cent were unknown, while 43 per cent of the ischemic heart disease classification were unknown, and 76 per cent of those with other forms of heart disease were unknown.

It is not realistic to propose that the screening program as described supplied specific answers to all of the questions surrounding health screening procedures. Much has been done. However, much remains to be done to increase the effectiveness of such programs. First, to address the questionnaire—experience has demonstrated the necessity of professional review, or a second review by the participant, of his positive responses. In the program described, this requirement has been met by having the nurse review and elaborate upon the positive responses. An additional question is how reproducible are the results of the positive and negative answers to specific questions. We are moving into the second year and will be evaluating the accuracy of individual responses using the same questionnaire for a second examination for approximately 2000 employees age 60 or over.

Another reasonable question is, "What are the most productive questions that can be asked through such a technique, and which questions are nonproductive?" This requires several approaches. With a statistical data bank of over 26,000 questionnaires, each consisting of 167 questions, we will be addressing these problems. We consider these steps necessary for the further refinement of this questionnaire, as well as for the development of more abbreviated questionnaires to be used in the future for employees from whom we have obtained the base information. The questionnaire as presently constituted incorporates, in our judgment, the most pertinent questions secured from review of many other questionnaires in use elsewhere.

The laboratory also presents some interesting areas for refinement. Quality control is essential. The control measures begin with a daily computer check of known standards to ascertain that the results of each chemistry are within the acceptable range. If these requirements are not met, the computer does not process. After every tenth sample, a standard specimen is processed and the computer corrects for any changes that occur in the system. Frozen serum from a previously standardized pool is processed daily to verify laboratory reproducibility. Commercial serum in normal and abnormal ranges are also used to verify chemistries each day. The computer calculates the mean for the results of all chemistries at the end of each day and compares with the accumulated laboratory mean.

In addition to these control measures, the laboratory also processes and reports upon unknown specimens supplied by the licensing state agency. The results of the analysis of unknown specimens have uniformly met the highest standards of the state. The third method is a monthly interlaboratory comparison. Each laboratory processes portions of the same specimens and a high correlation of results has been found.[4] One requirement for evaluating the laboratory findings in a screening program is the establishment of expected ranges for each chemistry for the specific population receiving the examinations. The parameters of expected ranges would be influenced by age, sex, geography and race.[5] In exploring our data bank, we have already seen the shifts in some of the laboratory findings which are related exclusively to age. For example, in our early study of over 9000 results the basic population had a mean of 101 mg per cent. We note the increase in mean glucose levels

changing with different age groups. For the age group 41 through 45 the mean is 100 mg per cent; the age group 51 through 60 has a mean of 102 mg percent, and this increases to 103 mg per cent for the age group over 60.

In 25 of the 38 medical departments, we use electrocardiographic equipment which records not only the conventional paper output, but also has provisions for the recording of the analog signals of the vectorcardiogram on tape. The computer programming for the interpretation of the vectorcardiogram provides the necessary reliability for use in screening examination programs.[6] During the first month of the examination program, we ran parallel reporting of both computer output and cardiologists' interpretations. Within the normal group, we found there was 98 per cent agreement on the interpretations. The computer tends to over-interpret the electrocardiograms for normal and to place more in the borderline classification. To provide quality control, we have the provision that the computer output for borderlines and abnormals are all reviewed by cardiologists and that their interpretation will override the computer in the final printout of the individual examination report.

Additionally, to prevent against the possibility of programming error, or computer failure, every 20th electrocardiogram is interpreted by the cardiologist. In those locations that do not have the capability of recording the vectorcardiogram on tape, the usual electrocardiogram recordings are submitted with the examination and interpreted by the cardiologist. This approach relieves the cardiologist of interpretation of more than 60 per cent of the electrocardiograms submitted.

In summary, we believe that screening programs, using machine processable questionnaires and nurse or technician observations in machine processable form, along with the laboratory, electrocardiography and X-ray procedures as described, demonstrate a technique of providing examinations to a mass population. This approach has been acceptable to the participant and has demonstrated the capabilities of detecting disease processes unknown to the participant. We recognize the need for stringent quality control measures, as well as a requirement for further refinement of health screening techniques.

Bibliography

1. Grimaldi, John V.: "The Worth of Occupational Health Programs: A New Evaluation of Periodic Physican Examinations," *Journal of Occupational Medicine.* Vol. 7., No. 8. pp. 365-374, August 1965.

2. Ritzau, Louise C., R.N.: "Health Screening Examinations: A Pilot Study." *Occupational Health Nursing.* Vol. 17. pp. 15-16, January 1969.

3. Collen, M. F.: "Periodic Health Examinations Using An Automated Multitest Laboratory." *Journal of the American Medical Association.* Vol. 195, pp. 830-833, March 7, 1966.
Collen, M. F., Rubin, L., and Davis, L.: "Computers in Multiphasic Screening," Chapter 14. Stacy, R. W. and Waxman, B. D.: "Computers in Biomedical Research," Vol. 1, Academic Press, Inc. New York 1965.

4. Derman, H.: Personal notes from speech at annual meeting of Association of Clinical Scientists, Mobile, Alabama. April 26, 1969.

5. Best, W. R., Mason, C. C., Barron S. S., Shepherd, H. G.: "Automated twelve-channel serum screening: 1. What is normal?" *Medical Clinics of North America.* 53:(1) pp. 175-187, January 1969.

6. Smith, R. E., Hyde, C. M.: "A Computer System for Electrocardiographic Analysis." *Third Annual Rocky Mountain Bioengineering Symposium.* University of Colorado, Boulder. May 2-3, 1966. Engineering Publications, Rochester, Minnesota.

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Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in the Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

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Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the lutenizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates in the United States found relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives. This has not been confirmed in the United States.



Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for 2 months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: Increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

1. Royal College of General Practitioners: Oral Contraception and Thromboembolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967.

2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968.

3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969.

4. American Journal of Epidemiology (to be published).

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12-14 Annual Meeting, Kentucky Chapter, American College of Surgeons, Imperial House, Lexington

18-20 Postgraduate course, "The Head of the Child," University of Kentucky Medical Center, Lexington.

18 PANMED television series, "Patterns of Nursing I," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

23 PANMED television series, "Patterns of Nursing—I," in Louisville, WKPC-TV 10 p.m.

25-26 "Symposium on Cardiovascular Disease," sponsored by the Heart Association of Louisville and Jefferson County, Stouffer's Louisville Inn.

25 PANMED television series, "Preparation of the Child for the Hospital," KETV-TV 10:00 p.m. EST (9:00 p.m. CST)

30 PANMED television series, "Preparation of the Child for the Hospital," in Louisville, WKPC-TV 10 p.m.

APRIL

1 PANMED television series, "Return," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

1-3 Annual Meeting, Kentucky Public Health Association, Kentucky Hotel, Louisville

2 Fifteenth Annual Spring Clinical Conference, Lexington Clinic, "Diabetes Mellitus-1970," Lexington

3-4 Postgraduate course, "Cancer and the Family Physician," University of Kentucky Medical Center, Lexington

6 PANMED television series, "Return," in Louisville, WKPC-TV 10 p.m.

7 KMA Senior Day Program, Continental Inn, Lexington

8-9 KMA INTERIM MEETING, "Kentucky Medicine in the 70's," Kentucky Dam Village State Park, Gilbertsvile

8 PANMED television series, "Detection of Oral Cancer," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

13 PANMED television series, "Detection of Oral Cancer," in Louisville, WKPC-TV 10 p.m.

15 PANMED television series. "Family Prescription Records," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

17-18 Postgraduate course, "Ill Winds," on current progress in respiratory therapy; Fee: $25; University of Kentucky Medical Center, Lexington

20 PANMED television series, "Family Prescription Records," in Louisville, WKPC-TV 10 p.m.

21 Annual Southern Medical Association lectureship, "Trends in Malpractice Litigation" by Vincent Collins, M.D., L.L.B., 8 p.m., University of Kentucky Medical Center, Lexington

23 Annual Rheumatic Disease Symposium, Louisville General Hospital's Rankin Amphitheater, Louisville

MAY

5-8 Annual Meeting, Kentucky Academy of General Practice, Convention Center, Louisville

8-9 Symposium on gastrointestinal disease, "Bring Your Own Lesion," University of Kentucky Medical Center, Lexington

15-16 Annual Meeting, Kentucky Obstetrical and Gynecological Society, Brown Hotel, Louisville

15-16 Annual Meeting, Kentucky Surgical Society, Kentucky Dam Village State Park, Gilbertsville

23 Spring meeting, Kentucky Society of Anesthesiologists, Lexington

IN SURROUNDING STATES

MARCH

20-21 Fourth National Congress on the Socio-Economics of Health Care, Palmer House, Chicago, Ill.

APRIL

9-10 National Conference on Rural Health, sponsored by AMA's Council on Rural Health, Pfister Hotel & Tower, Milwaukee



SAMA's Summer in Kentucky: A Preliminary Evaluation

David Steinman, M.D., M.P.H.* and Joseph P. Deisher, M.D.**

AN UNUSUAL and significant summer program was carried out in Eastern Kentucky in 1969. It was a cooperative effort by members of the Student American Medical Association (SAMA), the Appalachian Regional Commission (ARC), the University of Kentucky (UK) Department of Community Medicine, Appalachian Regional Hospitals (ARH), and many practicing members of the medical and nursing professions. The basic objective was to introduce professional students to the geography, culture, problems and satisfactions associated with living in Southeastern Kentucky.

After a three day orientation period at the University of West Virginia in Morgantown, 88 medical students and 20 nursing students were assigned to five separate regions of Appalachia (Ohio-Pennsylvania, West Virginia, Kentucky, Virginia-North Carolina, Georgia-Alabama). Kentucky's allotment of 17 medical students and 3 nursing students was placed as shown on the map in Fig. 1.

The idea for the project arose from a conversation between Edward Martin, now president of SAMA, and Amos Johnson, M.D., Garland, North Carolina, past president of the American Academy of General Practice. Like many physicians in Appalachia, Doctor Johnson felt a real need to make known to medical students the special satisfactions to be gained from practice in a rural mountain community. The two originators took the idea to the ARC in Washington who agreed to fund a program to bring students into the area early in their medical careers so they could orient their future studies in line with their experiences. Through a cooperative effort of ARC with a field professor of Community Medicine from UK and the Office of Education, ARH, a local recipient-preceptor program was designed and cooperative planning was begun with SAMA.

*Field professor, Department of Community Medicine, University of Kentucky College of Medicine, Lexington

**Director of Continuing Medical Education, Appalachian Regional Hospitals, Office of Education, Harlan

Program Objectives

In the grant request which originally, officially, outlined the program, the objectives to be achieved are listed as follows:

"The overall objective of this program is to influence the career choices of medical and nursing students by exposing them to the health needs, the challenges and opportunities for service and the satisfactions and rewards of living and working in rural Appalachia during the critical, formative period of their professional lives. The impact of such an experience should be meaningful, not only to these students directly involved but also to their fellow professionals. Through the organizational and communications media available to SAMA, such experiences in rural practice can be shared with a large proportion of American medical and nursing students and senior members of the profession for a period of time much longer than the summer of 1969."

From this overall objective, five specific objectives were given:

1. To create among medical and nursing students an awareness of the common health problems, the gaps in health care and the general medical needs of a rural community.
2. To provide an opportunity to experience and identify with the role of a rural practitioner whereby the student will hopefully come to visualize himself in a future permanent role in Appalachia.
3. To broaden the understanding among the Appalachian physicians involved in the program of students' needs and goals.
4. Through the students to influence medical and nursing school curricula in a way that will tend to provide a larger output of personnel appropriately trained for the health needs of Appalachia.
5. To provide, on a limited basis, opportunities for medical and nursing students to give direct health service.

In the Kentucky Program, it was felt by the Director of Education, ARH, and the field professor, Community Medicine, that specific program objectives 1, 2 and 5 were very feasible ones with which

we could identify and provide sound experiences for achieving. The fourth specific would depend upon the students entirely when they returned to their various schools. Number 3 seemed to hold a certain amount of potential for friction and misunderstanding between the student and the preceptors. However, it was felt that if the students were reminded that they were preceptees with specific goals and were cautioned that there was little they could do to change the 300-year course of the Appalachian culture in eight weeks, their own natural courtesy and deference would prevent any real difficulty.

Student Selection and Placement

Any student who entered the program was obviously self-selected as interested in studying and possibly helping to improve the medical care delivery system for the area.

The students, generally in their pre-clinical years, came from Arkansas, California, Connecticut, District of Columbia, Georgia, Kansas, Pennsylvania and Wisconsin as well as from Kentucky. As a part of the selection process set up by SAMA, each student was required to submit his reasons for wanting to join the program in an essay type letter to the main offices of SAMA accompanied by a recommendation from the dean of his school. From these letters and an application form it was possible to identify the specific objectives held by the individual students. An effort was made to place the students with the type of practice that he thought he would be interested in observing. Seven students were placed with solo practitioners and ten students were placed with group practitioners; three observed general practice group practitioners and seven observed mixed specialty and general group practices.

The objectives of the various physicians were largely directed toward future recruitment of medical personnel into the area to help carry the heavy work load which falls on the shoulders of practicing health personnel in Appalachia.

The Kentucky Program

The original contact between ARC and the Office of Education, ARH, was made through a field professor of the Department of Community Medicine, UK. Conferences within the Office of Education revealed a sincere and active interest in the program, but also certain fears. The Appalachian culture is stiff with traditional forms and tightly laced with highly competitive political relationships. It was important that no friction arise which might upset the fine working relationship which the Department of Community Medicine has established over the years with the practicing physicians throughout Kentucky and especially in this area. The introduction of a group of "foreign" young people into this area, some of whom might be more militant than would be directly useful to any constructive purpose might cause problems, it was feared.

In order to insure that the problems in this regard were well understood by the students, two local



FIG. 1. Distribution of Students in Counties Eligible for Appalachian Regional Commission Funds

people accompanied the "faculty" to the orientation period in Morgantown and spent several hours conferring with the students, "telling it the way it really is", and answering any questions which any student cared to bring up. These local people were selected because of their familiarity with the culture at the grass roots level and their familiarity with the political relationships that the student might run into. After discussion with the SAMA planners, the Office of Education was able to reassure the Department of Community Medicine that any student who proved incompatible with the program through militancy would be removed.

In Kentucky the student area coordinator, Warren Grady Stumbo, now in his third year at UK's College of Medicine, worked closely with physician advisors and preceptors. He comes from an Appalachian county and was very forthright in reminding his peers coming into the area of the difficulties they might get into if they did not regard this summer solely as a learning experience.

During planning conferences with the representatives of SAMA, it became clear that they would insist on finding out their own information about the area. They rejected several offers concerning subject matter to be brought up during the orientation period. The physician staff for the Kentucky Program decided to then outline the process rather than the specific content through which the objectives might be achieved. The strategy proved to be acceptable to all concerned.

In its final form, the Kentucky Program had four parts: (1) The student's assignment to and working with a practitioner for the eight week period; (2) A suggestion that he get out into the neighborhoods and homes of the local people including those in which there were disease problems identified as

(Continued on page 169)

High

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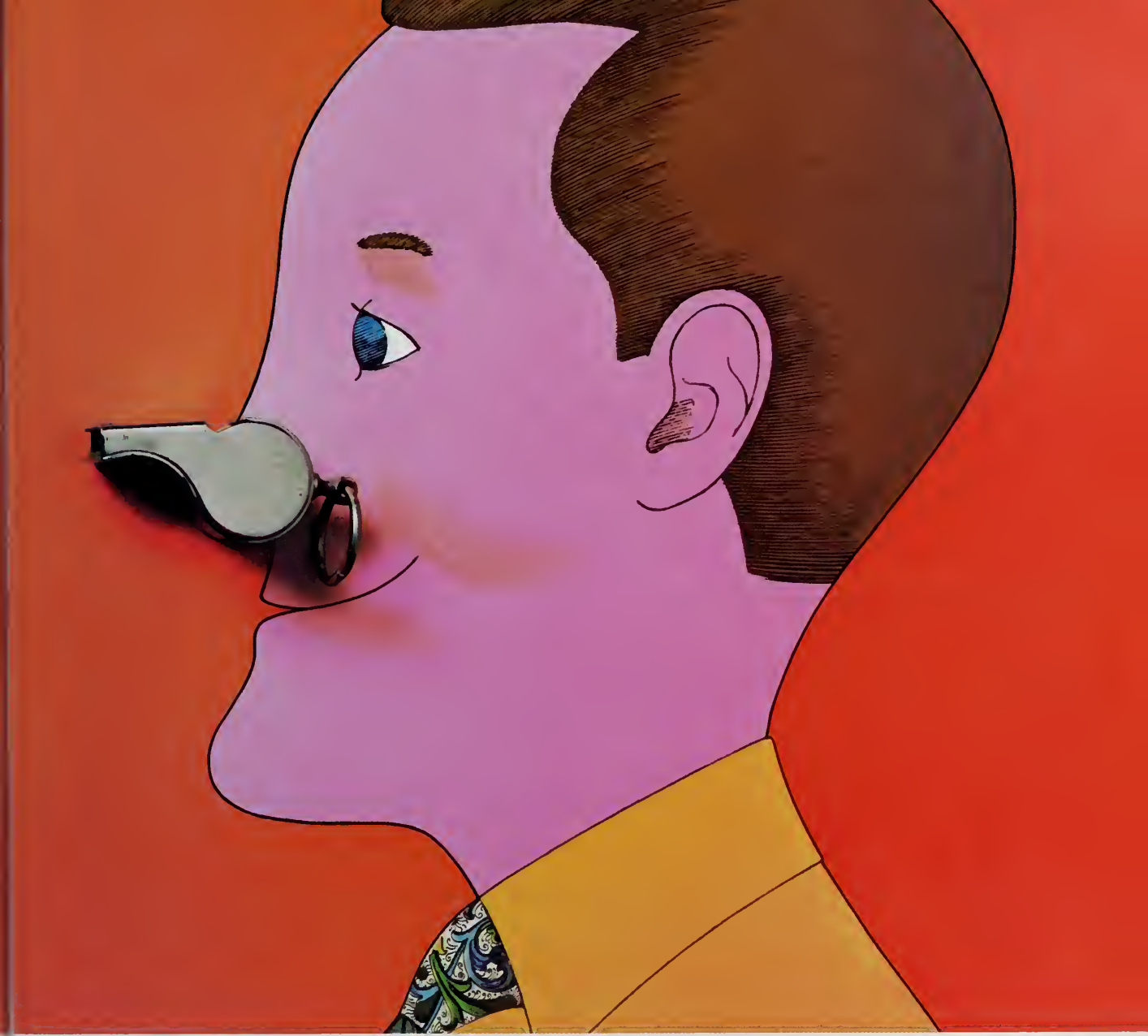
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A.H.F.S. Category 8:12

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Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
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Driver Escapes Serious Injury When Truck Jackknifes

SHENANDOAH, JULY 16. Roger Sherman of Waynesboro suffered head lacerations but escaped serious injury when the tractor-trailer he was driving skidded on Deep Run Bridge and jackknifed. It took rescue workers thirty minutes to remove him from the cab which was dangling over the edge of the bridge. Sherman is resting comfortably in University Hospital where his condition is listed as satisfactory.

Frankhouser called my attenti

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Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg. Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg. Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

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congenital, chronic, and mental/emotional; he was also advised to observe a home in which one member of the family was absent for an acute illness in the hospital; (3) A program for visiting and observing as many social agencies as possible, including not only the medical agencies, but those integral parts of the communities such as church, court, school board, service clubs and the like; (4) A written report was required at the end of the eight week period, which would take the form of either a narrative description, a collection of data related to testing of an hypothesis, or a critique of the program as a whole in terms of its organization, purposes, and content. It was felt that if these four themes were followed in addition to the Daily Log requirements set by the SAMA planners the students would be broadly exposed to the significant aspects of community and professional life.

The Director of Education, ARH, was chosen as the chief coordinating physician for the region. Two of the field professors of Community Medicine agreed to act as coordinating physicians also. From the roster of members of the Kentucky Academy of General Practice and the local practitioners who had served as field faculty for the Community Medicine fourth year students from UK, a group of physicians were selected who agreed to serve as directly supervising preceptors. The nursing students were placed with nurses, most of whom had been arranged for through the Student Nurses Association.

The physician advisors attended weekly conferences with the students and usually visited the site of their work. Their advice was requested on project matters, personal matters and questions of general interest to the area.

Evaluation

The evaluation program developed by SAMA headquarters for the summer's activities was extensive. In addition to detailed demographic data concerning himself, each participant was required to fill out questionnaires concerning attitudes toward health matters, community matters, and poverty and to take such tests as the Minnesota Multiphasic Personality Inventory and the California Personality Inventory. Most of these same tests were re-administered at the end of the eight week session. The results are being computer-analyzed by a SAMA member with a special background in behavorial science and statistics.

At the final meeting at Morgantown, the students expressed satisfaction with their experience. Many expressed interest in returning in future summers. A few expressed commitments to practice in the area.

An impressive list of projects was carried out by the Kentucky students.

This list included:

1. Is Aeromedical Rescue feasible in Southeastern Kentucky?
2. A study of hearing losses in Lynch, Kentucky.
3. A survey of young mothers: Willingness Toward Employment and Use of Day Care Centers.
4. Health education in McCreary County, Kentucky.
5. Evaluation of a family planning program.
6. Establishment of a volunteer program in a regional hospital.
7. Survey of immunization status of children.

These studies provide firm data on several priority problems of the region. The contribution is no small one, and serves as further justification of the program.

Preceptor Impressions

The 20 students were placed with 17 preceptors. Fourteen preceptors had a single student. Three preceptors had two students each. One pair of students was a husband-wife team.

Two months after the project terminated, the preceptors were interviewed in order to gain several impressions. The preceptors were asked "What is your general impression of the Summer SAMA Program at this point in time?"

Table I indicates that 88 per cent had positive feelings about the program. Almost a third (29 per cent) of physicians gave spontaneous superlatives in describing their impressions. One physician and one nurse preceptor had definite negative feelings about the program.

TABLE I

General Impression of Preceptors for Summer SAMA Program — 60 Days Afterward

	Superlative		Positive		Negative	
	No.	%	No.	%	No.	%
Medical Student Preceptor	4	29%	9	64%	1	7%
Nursing Student Preceptor	0	0%	2	67%	1	33%
TOTAL	4	23%	11	65%	2	12%

The preceptors were asked their reasons for the way they felt. Of the 15 preceptors in favor of the program 10 (67 per cent) were most impressed by the program concept, four (27 per cent) were most impressed by the qualities of their individual student, one (six per cent) was most impressed by the way the program was run.

The two preceptors with negative impressions had different reasons. One felt the student was responsible; the other felt the way the program was run was the chief reason for his feelings, but in addition faulted the program concept as well as the student.

The preceptors with positive impressions did have some criticisms. Six preceptors felt that the program should be limited to junior or senior students. Their reason generally was that it was difficult and too time-consuming to supervise the pre-clinical student in providing direct patient services.

Two preceptors felt the lack of proper direction and control of student activities. In one case the

(Continued on page 187)

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EDITORIALS

Want To Take A Trip?

"President's Office Sacked by Students"
"Record Room and Library Seized by Dissidents"
"Military Recruiters Attacked on Campus"
"Five Burn Draft Cards"
"Police Fired on from Dorm"

If you had been away for the past 10 years and just returned, it wouldn't take more than the above actual headlines to encourage the idea that it's not the same campus world. Indeed, it is not. People have made it so. To further alert you, may it also be suggested that it will never be the same—How many times has this phrase been uttered?

It's not all bad despite appearances, but it does take some contact, familiarization and some dialogue.

Muse for a moment—How many times have you returned to the campus, other than for an athletic event? Do it as soon as you can and you can anticipate a stimulating experience—a challenging thoughtfulness. It will not all depress you, neither will it all exhilarate you. If you wish to really seek and find appropriate discourse, adhere to three composures: "Ask, don't tell." "Go in peace, not in confrontation." "Don't appear as the seer, present as the seeker."

After a campus visit, it will be further contributory to your awareness to visit a medical school. The same three ground rules apply. For openers to see who our next generation of physicians are, try these propositions for starting familiarizations: "Health care and the proper methods for its delivery." "The best efforts of the profession to deal with the problems of the ghetto." "In reorganization of medical curriculi there should be a reduction in years of study and an enlargement of faculty (full-time and voluntary), but with divorcement of teaching from research." For the last item of discussion, take on something more philosophical, "Health care is a right, not a privilege."

Pursue the above suggestions and, while it will not cause a cessation of the generation gap, it will squeeze it ever so gently. Take a heavy dose of objectivity before going if you prefer to receive some scintillation.

We are now approaching our KMA Annual Senior Day. This will be the second year that both the University of Louisville and the University of Kentucky seniors will join together for the event. The date is Tuesday evening, April 7. The place is Continental Inn, Lexington. Host society for the evening events is the Fayette County Medical Society. All of you are invited.

Treat yourself to a generous helping of our next generation of physicians by joining in this event.

This generation will be with us shortly. If you don't avail yourself of such opportunities, it's conceivable there will soon be a generation gap plus two.

HOYT D. GARDNER, M.D., CHAIRMAN
SENIOR DAY COMMITTEE

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT SECTION

1970 Annual Meeting — Kentucky Medical Association

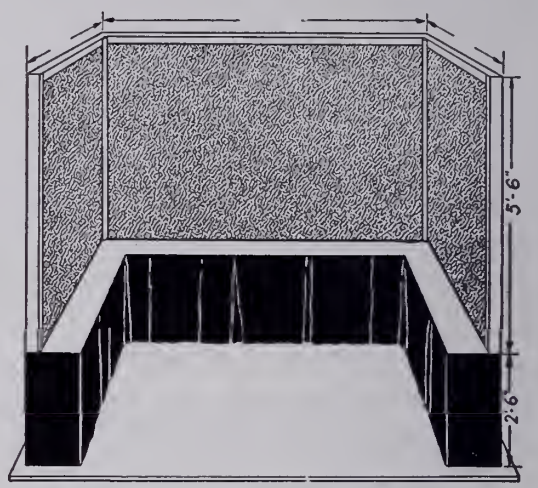
Convention Center — **Louisville, Kentucky** — **September 22, 23, 24**

Fill Out and Mail to:

T. R. MARSHALL, M.D., Chairman
Committee on Scientific Exhibits
Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, Kentucky 40205

Applications for space should be received before July 1, 1970

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....
   Institution (if desired): .....
   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)
   Charts and Posters.... Photographs.... Drawings.... X-rays ....
   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
   Amount of total wall space needed? .....
   Back wall .....Side walls (All side walls are 4') .....
   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided to you in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....
Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

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BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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ORGANIZATION SECTION

Discussion of Peer Review, Physician's Assistant Featured At 1970 KMA Interim Mtg., April 8-9, Ky. Dam Village

The 1970 KMA Interim Meeting will feature informative and interesting discussions on Peer Review and the Physician's Assistant, two subjects which have great significance for the medical profession in the seventies.

Held at Kentucky Dam Village State Park, Gilbertsville, the 20th Annual Interim Meeting will begin on Wednesday, April 8, with a social hour and dinner followed by an address by Russell B. Roth, M.D., Erie, Pa., speaker of the AMA House of Delegates. Doctor Roth will discuss the aspects of providing health care in the next decade.

The Thursday morning program will begin with a panel discussion on Peer Review. Moderated by Walter L. Cawood, M.D., Ashland, KMA president, the panel includes John W. Koon, Louisville, executive secretary of the Kentucky Farm Bureau Federation; Vincent J. Santare, M.D., Munster, Ind., a member of the Board of Trustees of the Indiana State Medical Society, and Marvin A. Bowers, Jr., M.D., Louisville, chairman, KMA Claims and Utilization Review Committee. The participants will be discussing the consumer's viewpoint and KMA's guidelines on peer review.



J. Duffy Hancock, M.D. and Eugene H. Conner, M.D., both of Louisville, lend their assistance in replacing the Janet Avenue sign with Ephraim McDowell Drive, the new street name of the location of the KMA Headquarters Office. Doctors Hancock and Conner are members of the KMA Memorials Commission which sought the name change honoring the Kentucky pioneer surgeon.

Following this discussion will be a second panel which will deal with the subject of the Physician's Assistant. Participants in this panel, which is moderated by Walter I. Hume, Jr., M.D., Louisville, are Robert W. Ewer, M.D., Galveston, Texas, program director, Clinical Associate Program, University of Texas Medical Branch, and D. Robert Howard, M.D., Durham, N. C., project director, Physician's Assistant Program, Duke University School of Medicine.

The meeting will close Thursday with a luncheon and an address given by J. Ed McConnell, Louisville, president of Kentucky Physicians Mutual, Inc. and Blue Cross Hospital Plan, Inc. Mr. McConnell will speak on "Blue Cross-Blue Shield in Kentucky—Today."

Other activities planned during the two-day session include an Orientation Program, a meeting of the Woman's Auxiliary to KMA, as well as a meeting of the KMA Board of Trustees.

All physicians are urged to attend this meeting and to secure reservations as soon as possible. The deadline for making a reservation at Kentucky Dam Village State Park for the night of April 8 is March 25. A reservation form can be found on page 179 for your convenience.

Nominations for KMA Awards Accepted at Interim Mtg.

Nominations for KMA's three top awards will be accepted by the KMA Awards Committee during the 1970 Interim Meeting, according to Richard F. Grise, M.D., Bowling Green, committee chairman.

The committee will be seated at a reserved table during the April 9 luncheon and at that time will accept nominations for the Distinguished Service Medal Award, Outstanding General Practitioner Award and the R. Haynes Barr Award. These awards will be given during the KMA Annual Meeting in September.

Other members of the committee include William A. Blodgett, M.D., Louisville; Frank L. Duncan, M.D., Monticello; C. Wayne Franz, M.D., Ashland, and Douglas E. Scott, M.D., Lexington.



Doctor Roth

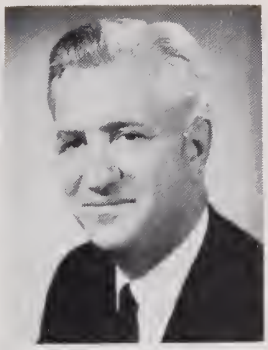
Program

"Kentucky Medicine in The Seventies"

KMA 1970 Interim Meeting

April 8 and 9

Kentucky Dam Village State Park
Gilbertsville



Mr. McConnell

WEDNESDAY EVENING SESSION

Walter L. Cawood, M.D., Ashland, president
Kentucky Medical Association, presiding

3:00 p.m. Registration

5:30 p.m. Social Hour

6:30 p.m. Dinner

7:30 p.m. Call to Order—Doctor Cawood
"Health Care in The Seventies"—Russell B. Roth, M.D.
Speaker, AMA House of Delegates

THURSDAY MORNING SESSION

Doctor Cawood presiding

8:45 a.m. Call to Order and Announcements

9:00 a.m. Panel Discussion—"Peer Review"
Walter L. Cawood, M.D., Ashland, moderator
Mr. John W. Koon, Louisville, executive secretary,
Kentucky Farm Bureau Federation
Vincent J. Santare, M.D., Munster, Ind.
Marvin A. Bowers, Jr., M.D., Louisville, chairman, KMA Claims
and Utilization Review Committee

10:30 a.m.—Panel Discussion—"The Physician's Assistant"
Walter I. Hume, Jr., M.D., Louisville, moderator
Robert W. Ewer, M.D., Galveston, Texas, program director,
Clinical Associate Program, University of Texas Medical Branch
D. Robert Howard, M.D., Durham, N.C., project director, Physician's
Assistant Program, Duke University School of Medicine

11:30 a.m. Question and Answer Session for Morning Program

LUNCHEON SESSION

12:30 p.m.

John C. Quertermous, M.D., Murray
KMA President-elect, presiding

"Blue Cross-Blue Shield in Kentucky—Today"—J. Ed McConnell, Louisville,
President, Kentucky Physicians Mutual, Inc. and Blue Cross Hospital Plan, Inc.

Adjournment



Mr. Koon



Doctor Bowers



Doctor Ewer



Doctor Howard

Redesigned Orientation Course To Be Offered April 8

The Tenth KMA Orientation Course, which has recently been redesigned, will be offered for new members of the Association April 8, just prior to the opening of the 1970 Interim Meeting at Kentucky Dam Village State Park, Gilbertsville.

The Orientation Committee changed the format of the program this year placing more emphasis on brevity and informality. The program is designed to better equip new members to meet present-day responsibilities as a citizen and as a physician.

According to the KMA Bylaws, new members are required to attend an orientation course within two years of joining the Association, unless excused for a cause approved by the Board of Trustees.

Letters of invitation for this course, which is held twice each year in connection with the Interim and Annual Meetings, have been sent to new members. Any KMA member, whether he receives an invitation or not, is most welcome to attend the session.

Rheumatic Disease Symposium Scheduled For April 23

"New Concepts and Procedures in Rheumatic Diseases" will be the theme of the Sixth Annual Rheumatic Disease Symposium April 23, according to David H. Neustadt, M.D., Louisville, chief of the section on rheumatic diseases, University of Louisville.

The full-day conference, which will be held in Louisville General Hospital's Rankin Amphitheater, is sponsored by the University of Louisville School of Medicine and the Kentucky Chapter of the Arthritis Foundation.

Included in the guest faculty are Joseph L. Hollander, M.D., chief of the arthritis section, University of Pennsylvania, Philadelphia, and Nathan Zvaifler, M.D., chief, division of rheumatic diseases, Georgetown University Medical Center, Washington, D.C.

Discussion at the conference will deal with recent advances and developments in diagnosis and treatment of rheumatoid arthritis, gout, ankylosing spondylitis and septic arthritis. Panel discussions with active audience participation and question and answer sessions will be encouraged, Doctor Neustadt said.

Large industrial and private medical practice, well equipped office, X-ray, E.K.G., two large good hospitals within five minutes. M.D. age 66 desiring to quit within two years. Salary, then percentage. Write: W. C. Madden, M.D., 713 Washington Street, Dayton, Ohio 45407.

Cancer Symposium Presented At OB-GYN Mtg. May 15-16

The Kentucky Obstetrical and Gynecological Society will hold its 22nd Annual Meeting May 15-16 at the Brown Hotel, Louisville. The meeting is co-sponsored by the Kentucky Division of the American Cancer Society.

Four nationally-known speakers will participate in the meeting on May 15 which will be a symposium on gynecological cancer. Donald J. Woodruff, M.D., professor of gynecology and obstetrics at Johns Hopkins University, Baltimore, Md., will discuss the field theory of squamous carcinomas in the female and ovarian tumors.

Discussing the surgical approach to vulvar cancer and the epidemiology of cervical cancer will be Professor Stanley Way, Newcastle-on-Tyne, England.

James Krieger, M.D., chief of gynecologic service, Cleveland Clinic, will deal with dysplasia and adenomatous hyperplasia. Trophoblastic tumors and chemotherapy in gynecologic malignancies will be the topics of John L. Lewis, Jr., M.D., chief of gynecologic service, Memorial Hospital, New York City.

Ky. Surgeons Hold Annual Mtg. March 12-14 in Lexington

The annual meeting of the Kentucky Chapter, American College of Surgeons will be held March 12-14 at the Imperial House in Lexington, according to Sam Weakley, M.D., Louisville, secretary of the chapter.

Featured on the three-day program will be two former Kentucky physicians. Frank C. Spencer, M.D., chairman of the department of surgery of the New York University School of Medicine, is a former surgery professor of the University of Kentucky School of Medicine and a former recipient of the KMA Faculty Achievement Award.

Ben Eiseman, M.D., another guest speaker at the meeting, was the first chairman of the department of surgery at the University of Kentucky. Now a surgery professor at the University of Colorado Medical School, Doctor Eiseman is also director of surgery at Denver General Hospital.

Call for Abstracts

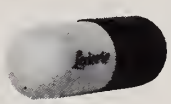
The 1970 meeting of the American Electroencephalographic Society wlil be held September 17-19 in Washington, D.C. Any member, or nonmember, desiring to submit abstracts for presentation at the meeting must do so before June 1. The abstracts should be submitted to Reginald Bickford, M.D., Department of Neuroscience, University of California, LaJolla, Calif. 92037.

Doctor, after all we've been through together...

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listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
psittacosis
pyelonephritis
Rocky Mountain spotted fever
scarlet fever
septicemias
sinusitis
soft tissue infection
tonsillitis
tularemia
typhus fever
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Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
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(*Continued from page 153*)

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References

1. O'Quinn, S.E., Kennedy, B., and Baker, D. T. Peripheral Vascular Lesions in Rheumatoid Arthritis. *Arch Derm* 92:489-492, (Nov) 1965.
2. Ayres, Samuel, Jr., and Ayres, Samuel. Pyoderma Gangrenosum with an Unusual Syndrome of Ulcers, Vesicles and Arthritis. *Arch Derm* 77:269-280, (Mar) 1958.
3. Perry, H. O. and Brunsting, L. A. Pyoderma Gangrenosum. *Arch Derm* 75:380-386, (Mar) 1957.
4. Perry, Harold. Details Given on 62 Cases of Pyoderma Gangrenosum, *Med Trib* 10:1 and 23, (Jan 20) 1969.
5. Kiel, V. L. Pyoderma Gangrenosum in Ulcerative Colitis. *Arch Derm* 56:187-190, (Aug) 1947.
6. Long, P. I. and Uesu, C. T. Pyoderma Gangrenosum. *JAMA* 187:336-339, (Feb 1) 1964.
7. Meleney, F. L. and Johnson, B. A. Further Laboratory and Clinical Experiences in the Treatment of Chronic Undermining Burrowing Ulcers with Zinc Peroxide. *Surg* 1:169-219, (Feb) 1937.

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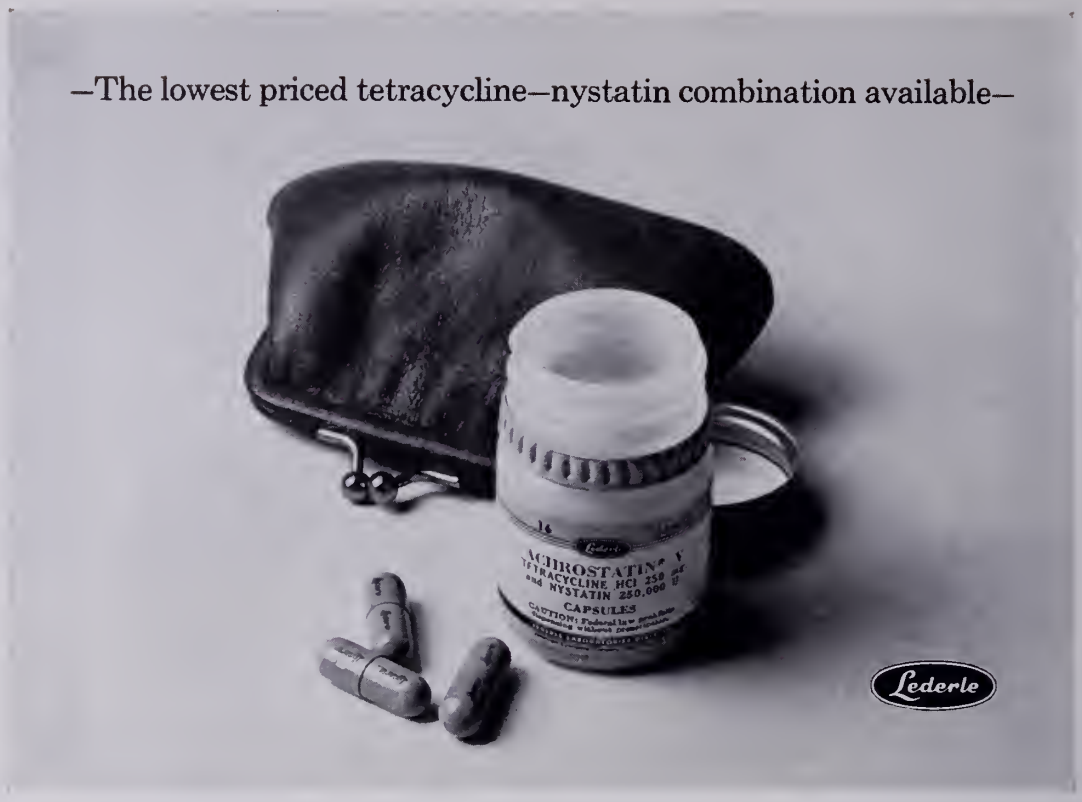
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Key Man Orientation Conference Held January 15 in Frankfort

The Committee on Legislative Activities was most pleased that 65 physicians and guests attended the Key Man Orientation Conference January 15 in Frankfort. Hoyt D. Gardner, M.D., Louisville, is the Committee's chairman for National Affairs and Fred C. Rainey, M.D., Elizabethtown, is chairman for State Affairs.

The morning session was devoted to an explanation of the KMA Legislative Key Man System. Richard S. Wilbur, M.D., assistant executive vice president of the American Medical Association, was the keynote speaker for the morning session.

Guest speaker for the luncheon was KMA President Walter L. Cawood, M.D., Ashland, who spoke on the current legislative climate and effective participation by key men and physicians in influencing the enactment of legislation in the public interest.

County Society Officers Named For 1970 Associational Year

Following is a list of the county society officers for the coming year, according to the records of the membership department February 15:

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(*Continued from page 148*)

References

1. Berman, Edward J. & Kimble, John: Barium Enema for Intussusception in Infants and Children. *Archives of Surg.*, Vol. 92, 508-513, 1966.
2. Bjarnason, G. & Patterson, G.: The Treatment of Intussusception: Thirty Years Experience at Gothenburgs Children's Hospital. *Jour. of Ped. Surg.*, Vol. 3, 19-23, 1968.
3. Marks, Richard M., Sieber, William K. & Girdany, Bertram R.: Hydrostatic Pressure in the Treatment of Ileocolic Intussusception in Infants & Children. *Jour. Ped. Surg.*, Vol. 1, 566-570, 1966.
4. Packard, George B. & Parker, Allen R.: Intussusception. *Surg.*, Vol. 45, 496-505, 1959.
5. Ravitch, Mark M.: *Ped. Surg. Year Book Medical Publishers.* Vol. 2, 751-769, 1962.
6. Swenson, Orvar: *Pediatric Surg.* 3rd Edition, Vol. 1, Appleton-Century-Crofts.



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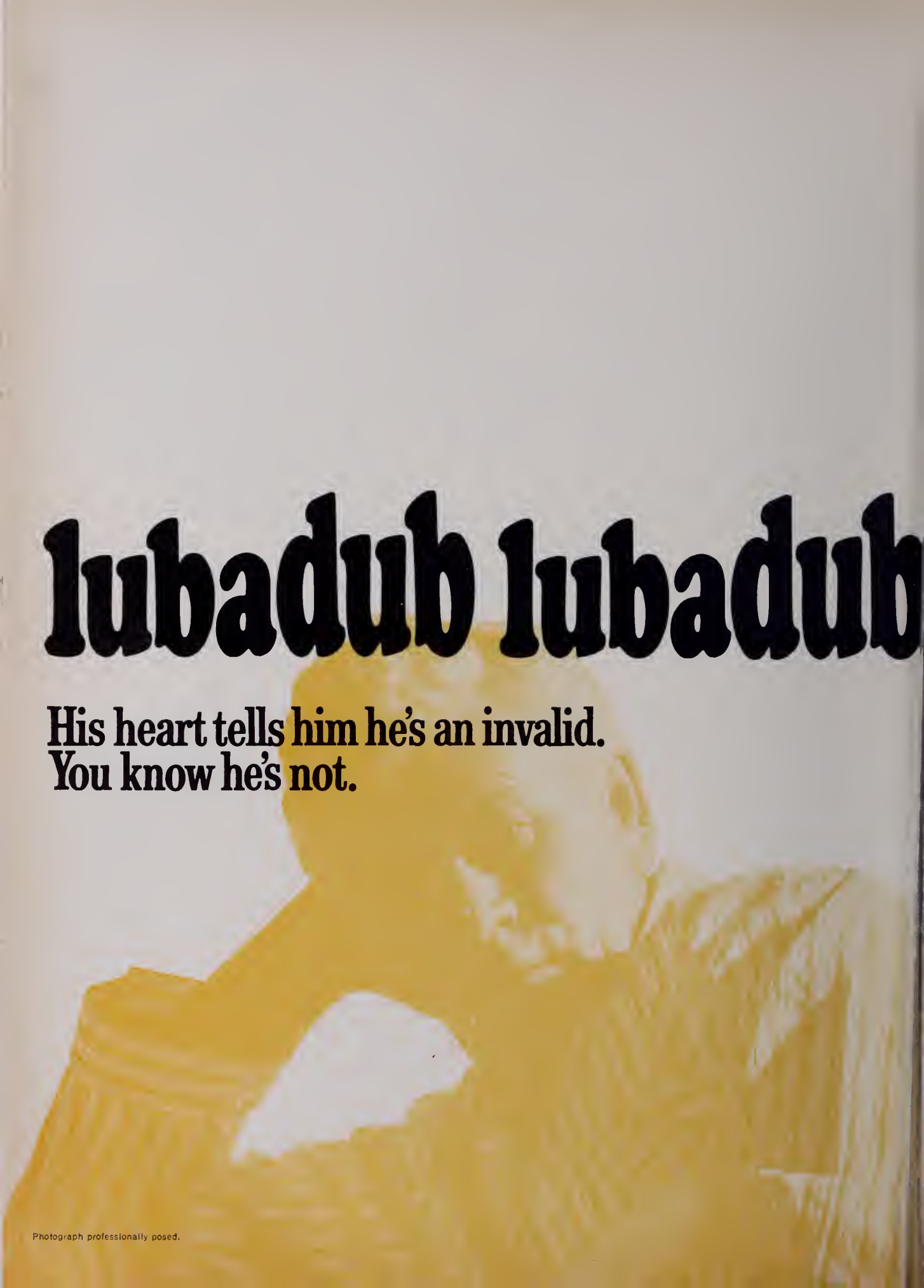
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KMA Committee Reports

Educational Television Committee

Thomas L. Heavern, Jr., M.D., Highland Heights, Chairman, Presiding

University of Kentucky College of Medicine — **January 20, 1970**

The KMA Educational Television Committee held its third meeting of the Associational year in Lexington recently. Discussion centered around the committee's plans for surveying Kentucky physicians to determine the effectiveness of the series to date and the best methods of promoting the series.

The next PANMED programs of special interest to physicians are "Preparatoin of the Child for the Hospital" on March 25; "Exercise and the Heart" on April 29 and "Investigation, How Much?" on May 20. Complete details of the series can be found on the Continuing Educational Opportunities page of the KMA Journal each month.

Committee on Legislative Activities

Hoyt D. Gardner, M.D., Louisville, Chairman, National Affairs

Fred C. Rainey, M.D., Elizabethtown, Chairman, State Affairs

Frankfort, Kentucky — **January 15, 1970**, **February 5, 1970**

The KMA Committee on Legislative Activities met on January 15 and February 5, 1970, to discuss present and proposed legislation in regard to medical and health related matters. It was noted that the Committee routinely meets in Frankfort and more often when the Kentucky General Assembly is in session as it is now.

In an effort to coordinate legislative matters, representatives of the allied groups were in attendance at both meetings. The KMA "Quick Action" Committee was in attendance to formulate policy relating to the recommendations of the Committee members.

SAMA's Summer In Kentucky

(Continued from page 169)

preceptor did not appreciate the student's participation in an unendorsed Health Fair. One public health official criticized the students' requirement to "observe" rather than to get more involved in the work of the organization.

It remained apparent that the placement process was of great importance. Several preceptors were directors of institution-supported clinics. These clinics frequently operated with an appreciation and sensitivity to religious beliefs. Where the behavior of the student did not permit accommodation, reservation was expressed about the feasibility of the program.

The preceptors were asked about their impression of the students' objectives. There was unanimous agreement that objectives 1 and 2 (see above) were desirable. However 57 per cent of the medical students' preceptors questioned that the two months' experience would likely bring the student to Appalachia as a permanent professional.

Objective 3, to broaden the understanding among the Appalachian physician of students' needs and goals, found agreement about its desirability in only 36 per cent of the medical student preceptors. Likewise, only 36 per cent felt the objective was realistic. The majority which did not agree, stated thay did not understand, or preferred not to comment.

Objective 4, to influence school curricula, was found desirable by 88 per cent of the preceptors. Half of the medical student preceptors questioned the realism of this objective, however.

Finally, 82 per cent of the preceptors agreed that it was desirable for the students to give direct health services. One-third (36 per cent) did not agree that this was realistic.

Discussion

After preliminary evaluation, it appears that the SAMA Appalachian Program is a benefit to the area. After the first summer, the students and the preceptors have positive impressions in the great majority of cases. It appears that the program can evolve into a truly productive experience.

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POST-GRADUATE SYMPOSIUM ON RHEUMATIC DISEASES

Rankin Amphitheater **APRIL 23, 1970** Louisville General Hospital

SPONSORED BY THE UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE AND THE KENTUCKY ARTHRITIS FOUNDATION

FOREWORD: NEW CONCEPTS AND PROCEDURES IN RHEUMATIC DISEASES

This symposium will emphasize new procedures and concepts concerning pathogenesis and diagnosis of inflammation and rheumatic diseases. Clinical application of recent therapeutic advances will be stressed. Particular attention will be given to: recent immunologic and diagnostic knowledge related to rheumatoid arthritis and synovial fluid; arthroscopy, a new technique for distinguishing pathologic features of the various arthritides; new information on joint infections; diagnosis and modern management of ankylosing spondylitis; and new developments related to gout and uric acid metabolism. Panel discussions with active audience participation will supplement the morning and afternoon sessions.

JOSEPH L. HOLLANDER, M.D. Philadelphia, Pennsylvania	*Synovial Fluid: Diagnostic and Pathogenetic Aspects*
RICHARD LIPSON, M.D. Burlington, Vermont	*Arthroscopy: New Procedure in Rheumatic Diseases*
FRANK R. SCHMID, M.D. Chicago, Illinois	*Septic Arthritis: Newer Knowledge*
JOHN W. SIGLER, M.D. Detroit, Michigan	*Current Comment on Diagnosis and Management of Ankylosing Spondylitis*
JAMES B. WYNGAARDEN, M.D. Durham, North Carolina	*Gout: Recent Developments and Advances in Therapy*
NATHAN J. ZVAIFLER, M.D. Washington, D.C.	*Immunologic Aspects of Rheumatoid Arthritis*

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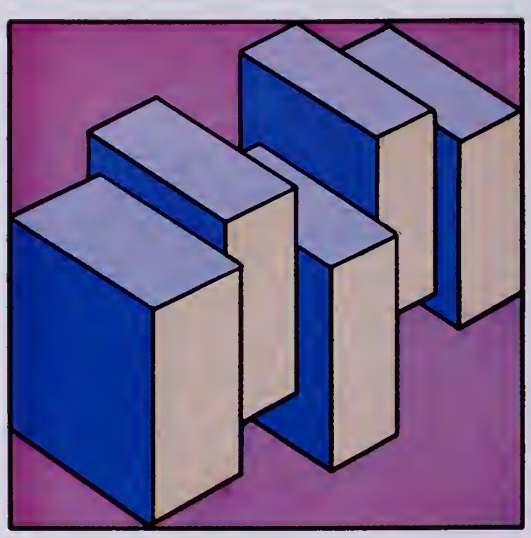
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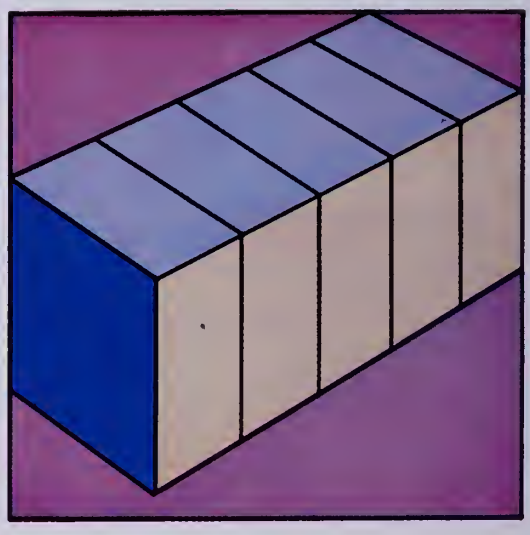
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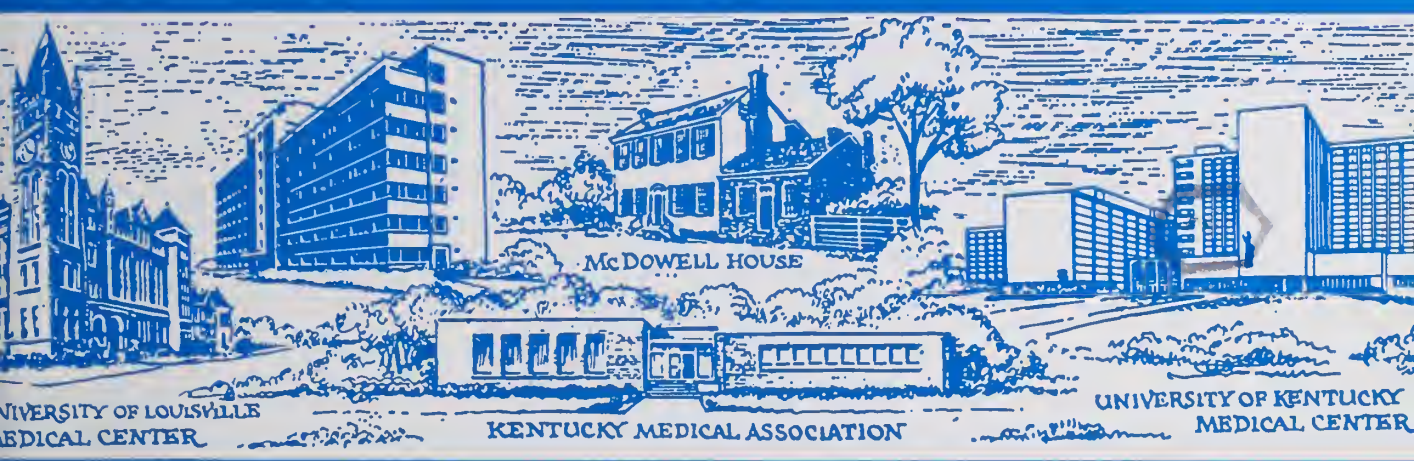
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The Journal of The KENTUCKY Medical Association



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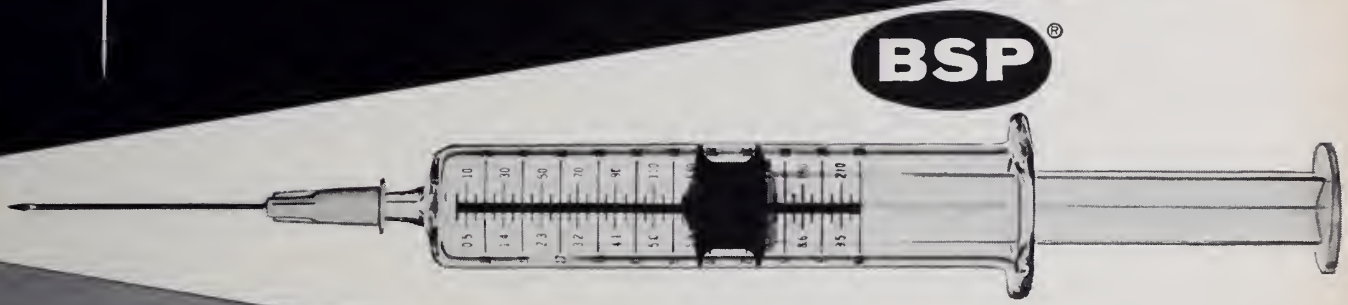
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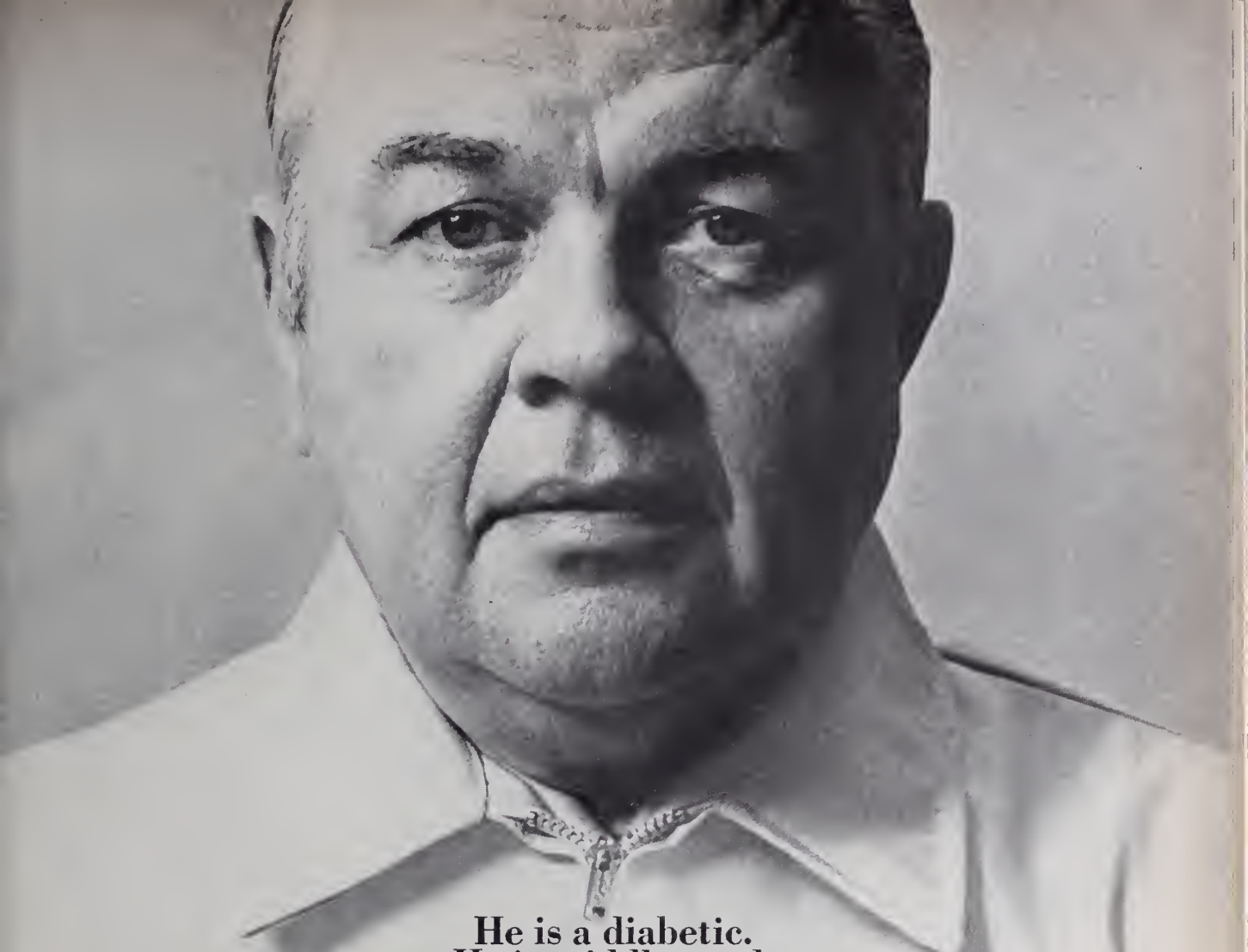
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

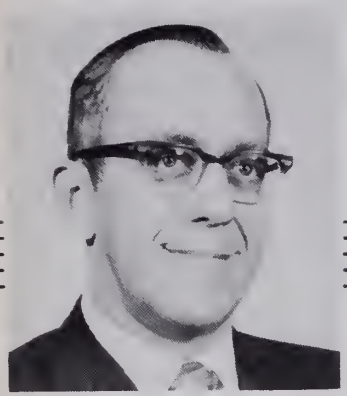
Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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MESSAGE FROM THE PRESIDENT



EXPLORATION of a new area usually yields some surprises, frequently raises questions and occasionally produces new knowledge. KMA entered such a new area three years ago when it began studying television techniques for continuing education of physicians. Dr. Walter Cawood has generously allowed the E.T.V. Committee the use of his President's Page to share some of the knowledge we have gained about this complex medium and to answer a few of the questions of the PANMED audience.

The inauguration of the Kentucky Educational Television Network (KETV) in the fall of 1969 provided an opportunity to reach virtually every physician in Kentucky by open broadcast. This method obviates the need for expensive reception equipment required with most closed broadcast plans. KETV has 12 transmitters scattered through the state. Until the KETV channel in Louisville begins operation, Channel 15, WKPC-TV has agreed to transmit our programs. Generous grants from the Kentucky Heart Association and the Kentucky Chapter, American Cancer Society have allowed us to obtain high quality pre-recorded tapes with carefully programmed material. Representatives of the University of Kentucky and University of Louisville Medical Schools provide guidance in program selection. University of Kentucky Television contributes the technical knowledge and assistance that make the PANMED series a reality.

The use of open broadcast, even late at night, imposes some restrictions on program material. High production cost prevents us from originating complete programs from Kentucky medical centers at this time. Yet, within these limitations, we hope to provide a worthwhile service for physicians throughout the state. We hope to point out new areas of medical interest and to view old areas in a new light. We hope that physicians might then be stimulated to further discussions with each other and further independent study of the material presented. We hope they may also become aware of and pursue other opportunities for continuing medical education in Kentucky as a result of our announcements. And if somehow, somewhere a few "pearls" fall into the hands of a few physicians, we'll view it as a gratuitous benefit.

The Ohio Valley Regional Medical Program awarded us a grant to survey the effectiveness of these programs. The results of that survey are encouraging but the reactions of all KMA members will determine the future course of this series. We urgently solicit your comments. If you wish, and if our grants are renewed, we anticipate another season featuring increased local comment relating these tapes to medicine in Kentucky.

THOMAS L. HEAVERN, M.D., CHAIRMAN
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This is the fourth in a series of articles written at the request of KMA President Walter L. Cawood, M. D.

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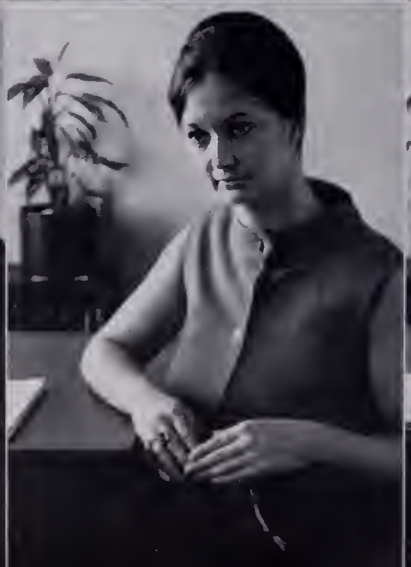
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Formula: CANDEPTIN Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% candicidin activity in U.S.P. petrolatum. 3 mg. of candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain candicidin powder equivalent to 3 mg. (0.3%) candicidin activity dispersed in starch, lactose and magnesium stearate.

Indications: Vaginal moniliasis due to *Candida albicans* and other Candida species.

Contraindications: Patient sensitivity to any of the components. During pregnancy manual tablet insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment or Vaginal Tablets have been extremely rare. To avoid reinfection, it is recommended that the patient refrain from sexual intercourse during treatment or the husband wear a condom.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet is inserted high in the vagina, twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Dosage forms: CANDEPTIN Vaginal Ointment is supplied in 75 gm. tubes with applicator (14-day regimen requires 2 tubes). CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil, with inserter—enough for a full course of treatment. Store under refrigeration.

Federal law prohibits dispensing without prescription. CANDEPTIN is a registered trade-mark of Julius Schmid, Inc.

References: 1. Olsen, J. R.: Journal-Lancet *85*:287 (July) 1965. 2. Lechevalier, H.: Antibiotics Annual 1959-1960. New York, Antibiotica, Inc., 1960, pp. 614-618. 3. Giorlando, S. W., Torres, J. F., and Muscillo, G. Am. J. Obst. & Gynec. *90*:370 (Oct. 1) 1964. 4. Friedel, H. J.: Maryland M. J. *15*:36 (Feb.) 1966.

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FUNDAMENTALS OF INHALATION THERAPY: by Donald F. Egan, M.D.; Published by the C. V. Mosby Company, St. Louis, 1969; 474 pages, Price $11.00.

This volume was written as a textbook for inhalation therapists, and it is a very thorough one which also contains much material of interest to the physician. Only a few of its twelve chapters, such as those on the cardiovascular system and on clinical cardiopulmonary pathology, seem to have been "written down" to the level of paramedical personnel.

Just about all aspects of respiratory physiology are touched upon, from the gas laws to the mechanics of ventilation. While more detailed discussions of this material are available elsewhere, this volume presents the clinically important heart of the subject in an understandable form.

In the reviewer's opinion, the most useful portions of this volume are those devoted to the "how to do it" aspects of inhalation therapy. The inner workings of various mechanical ventilators, nebulizers and other apparatus are described in some detail, and their advantages and short-comings discussed. This type of information is not usually presented in texts directed at the medical profession, despite the fact that mechanical failures of equipment probably constitute a major hazard to patients being treated for respiratory failure.

The book is adequately illustrated, contains a number of excellent charts and tables, and has a useful appendix. It should be in every hospital library as a reference source, and every physician who uses mechanical ventilators and similar devices sould be familiar with it.

DONALD M. THOMAS, M.D.

CURRENT CONCEPTS IN OPHTHALMOLOGY: Vol. 2, by Bernard Becker, M.D. and Ronald M. Burde, M.D. with 17 contributors; Published by the C. V. Mosby Company, St. Louis, 1969; 267 pages; Price $21.00.

Current Concepts of Ophthalmology, is a compilation of topics selected by the authors for clarification in the light of present-day knowledge. The topics are discussed by the present and former staff of the department of ophthalmology, Washington University School of Medicine, St. Louis. The two authors have attempted to present an analysis of interesting problems in ophthalmology today.

The topics are rather far reaching with no attempt at continuity from subject to subject throughout the 17 chapters. The subjects range from techniques of corneal transplantation to cryosurgery, ophthalmic plastic surgery, thyroid ophthalmopathies, amblyopia and dyslexia.

Most of the individual presentations are generally well written with good photographs and drawings. Most are written in a very concise manner; some, I believe, too much so that no real value is obtained by the reader from the presentation. However, all but the chapter on dyslexia have excellent references for the reader to study. Discussions of herpes simplex keratitis, vitreoretinal pathology and cryosurgery of cataract are especially good sections.

This book is written primarily for the practicing ophthalmologist to help keep him current and supply an excellent reference list on the selected subjects. Non-ophthalmic practitioners would benefit from reading some sections, particularly those dealing with fluorescein angiography and thyroid ophthalmopathies. An eye resident would probably be seeking more detailed discussions of the subjects presented.

PETER C. CAMPBELL, M.D.

GUIDE TO CLINICAL LABORATORY DIAGNOSIS: by John A. Koepke; Published by Appleton-Century-Crofts, New York, 1969; 300 pages; Price $6.75.

This compact symptom-oriented book is 300 pages of easy paperback reading. It is a skeleton of clinical thinking. It is trimmed of theory and lengthy discussion. The author, intending to amplify the principles of laboratory testing, has succeeded in correlating basic and clinical sciences in a fashion meaningful to diagnosis and treatment.

The 23 chapters offer clinical pathology interpretations ranging from cough, FUO, renal disease, jaundice, bleeding abnormalities, and chest pain to pregnancy. The presentation is direct and simple. There are ample clinical features and clinical manifestations presented. Few controversial sections and only an occasional error exists.

The book is recommended as a guide to orient interns and residents in the field of clinical pathology, allowing intelligent selection of laboratory tests with subsequent maximum benefits.

For those who cannot afford the luxury of more detailed study, a few hours with this book will give the busy physician a thumbnail review and clinical correlation of all but the most esoteric tests. Whether general practitioner or specialist, it cannot fail to improve utilization of laboratory tests and to increase the diagnostic skill of those who order and interpret them.

CURTIS LEE SONGSTER, M.D.



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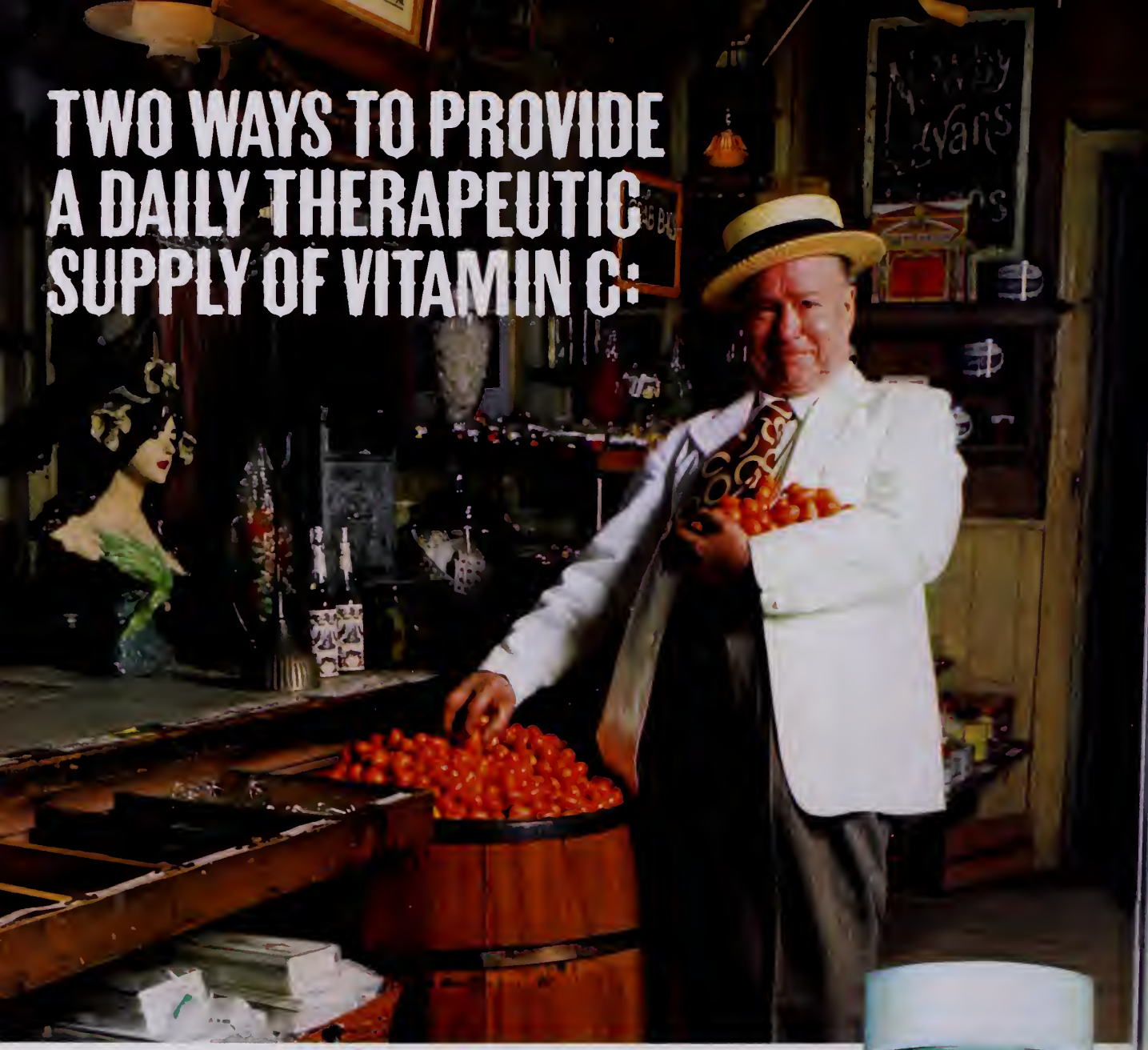
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From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 10-68. This 21-year-old married white housewife was admitted to the hospital April 13, 1968, with the chief complaint of persistent nosebleeds.

Previous history revealed that she was hospitalized three years before for an enlarged thyroid gland. The protein-bound iodine was 2.5 mcg percent and sodium levothyroxine was started. She did well until 18 months later; when further enlargement of the thyroid gland was noted. She was hospitalized for plural effusion and a report of malignant cells was obtained on the fluid. At another hospital repeat examination failed to demonstrate malignant cells. Bronchoscopy, mediastinoscopy, scalene node biopsy were performed but no definite diagnosis could be made. Needle biopsy of the thyroid revealed Hashimoto's thyroiditis. At thoracostomy, a thymoma involving the left upper lobe, the pericardium plus the chest wall was found. Post-operatively, she received 4,500 R to the mass, and responded well. She was re-admitted to the hospital three months prior to the present admission, because of fullness in her chest. Examination revealed Hemophilus influenza bronchitis. She responded to ampicillin.

At the present admission, April 13, 1968, she was afebrile, blood pressure was 96/60, and did not appear acutely ill. Purpuric lesions over the arms and legs were noted. The optic fundi were normal. The thyroid was diffusely enlarged, firm and somewhat tender. The trachea was in the midline. Decreased chest expansion, dullness over the entire left hemithorax, with increased tactile fremitus were observed. The liver edge was felt two fingerbreadths below the right costal margin. Hematocrit was 31 per cent, WBC 3,300 with 69 per cent lymphs. The platelet count was 7,500. Bone marrow examination was hypoplastic. The urinalysis was negative.

On the second hospital day, April 14, Prednisone was started 100 mg daily, plus 6 mgs Winstrol (heterocyclic steroid) daily and thyroid extract 120 mgs. daily. She received Codeine for her cough.

On April 17, the fourth hospital day, she began to have lower abdominal cramping and some vaginal bleeding. She passed products of conception. The last menstrual period wasn't given. She had a curettage of the uterus and received syntocinon, IV fluids and ampicillin 2 gms daily. She received two units of blood following the abortion.

On the 13th hospital day, she developed oral thrush and was treated with nystatin. She ran a high fever the following day and was started on sodium cephalothin and kanamycin sulfate after blood cultures were obtained. These subsequently grew E. Coli which was the organism also cultured from the endocervix after the abortion.

Her platelet and white blood count remained low although she did show a response to both fresh blood and fresh plasma, raising her platelet count from 5,000 to about 35,000. This was interpreted to the thrombopoietic effect of the blood and plasma. She continued to have a leukopenia, the WBC ranged between 250 and 2,000 with 100 per cent lymphocytes. She received a repeat course of irradiation to the left hemithorax, about 1500 R, in the hope that irradiation of the thymoma might reverse the pancytopenia. There was no improvement. She continued to have a high spiking fever, even on the antibiotics. Blood culture May 9, revealed E. Coli. She was started on polymyxin B 2 mgs/kilo per day.

In spite of antibiotics, consisting of polymyxin B, ampicillin, sodium cephalothin and kanamycin sulfate, she continued to have high spiking fever, chills and her blood picture remained unchanged. She received blood to maintain her hematocrit above 30 per cent, plus fresh blood and fresh plasma in an attempt to maintain her platelet count. On the 36th hospital day she died, May 18, 1968. Permission for post mortem examination was not obtained.

The final diagnosis was:

1) Thymoma involving the pericardium and pleura of the left hemithorax.

2) Pancytopenia, secondary to the thymoma.

3) Hashimoto's thyroiditis.

4) Complete abortion, with post-abortion endometritis, organism E. Coli.

5) E. Coli bacteremia, secondary to endometritis, and pancytopenia.

Comment

This most unusual case was classified by the Committee as an indirect obstetric death. In a study by Iverson[1] most of the cases previously diagnosed thymic carcinoma proved to be seminomatous tumors of the mediastinum. According to this report, differentiation from thymomas can be made by the histologic characteristics of the type cell, by a granulomatous reaction, by their radiosensitivity and by their evident malignancy. The question then is raised as to whether this case is one of seminomatous tumor, since the thymoma is regarded as a benign tumor.

(Continued on Page 252)

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General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

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THE INSURANCE PAGE



More About Peer Review

Peer review is an idea whose time has come. This is the message one hears from speakers throughout the country at various regional meetings.

The individual physician tends to become static and offer mediocre medical care if he is not constantly trying to update his records and keep supplying the best possible medical care for his patients.

James H. Sammons, M.D., of Baytown, Texas, who is chairman of the board of directors of the American Political Action Committee, has been quoted as saying that peer review should be concerned with the quality of care rather than charges for service. He further stated that he is bothered because peer review often seems to be punitive.

The writer tends to agree with this view. It is my view that each individual physician should attempt to document, in as few words as possible, that he is rendering quality medical care to his patients. The best way that I know of doing this is recording a carefully taken history, physical examination and up-to-date progress notes. When a chart that is properly recorded is reviewed, it is apparent to the reviewer that the patient has received quality care and that his attending physician is entitled to the charges for service.

Hugh A. Edmondson, M.D., who is a member of the utilization review committee at Methodist Hospital, St. Louis Park, Minn., has been quoted as saying that peer review is not a police function. He describes his hospital program as a "man-to-man approach with a great deal of education involved". When this approach is followed, the vast majority of hospital staff members have come to accept utilization review.

James B. Hampton, M.D., chairman of the utilization review committee at Portland, Oregon, Good Samaritan Hospital, was quoted by the AMA News as saying that the quality of medical care has improved in his hospital since utilization review began. "It is only natural that when you know someone is watching, you will be more careful. The documentation certainly has improved."

Because of the increased comprehensiveness of health care coverage, and its increased financial impact on medicine, peer review is needed. Donald C. Harrington, M.D., president of the San Joaquin County Foundation for Medical Care, Stockton, Calif., says that two basic requirements are seen for peer review. First is the involvement by physicians in "cleaning our own house" and second is involvement of physicians in programming for electronic data processing for third party programs. He further states that if practicing physicians do not become involved in peer review and do not get involved now to control providers of health care, we will not have the right to be included in any national health insurance that may be adopted.

At a recent conference attended by several individual physicians who are involved in peer review, informal remarks were exchanged between the members concerning some of the basic difficulties in peer review.

It was generally conceded that there may be a few cases of down-right over-utilization and over-charging. The greatest difficulty appears to be that physicians are not in the habit of documenting their medical records. Apparently many of us spend more time visiting with the nurses than we do writing in the chart.

As a hospital resident many years ago, the writer recalls that some of his colleagues who had worked in private hospitals remarked that even the clinical professors at the medical school made very poor hospitals records in

(Continued on Page 252)

A report from Kentucky BLUE SHIELD® for 1969 . . .

BLUE SHIELD® Membership

a. December 31, 1968	995,533
b. December 31, 1969	1,043,481
Net Enrollment Gain	47,948
Percent of Net Increase Over 1968	4.81%
Percent of Members Upgrading to Higher Benefit Programs	22.6%
Number of New Groups	951

BLUE SHIELD® Claims Experience

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Number of Claims Paid	217,452	
Amount Paid to Kentucky Physicians for Member Services		$8,592,907
b. **Usual and Customary Contracts**		
Number of Claims Paid	64,076	
(166, two-tenths of 1% of claims submitted, required Peer Review)		
Amount Paid to Kentucky Physicians for Member Services		$3,317,025
Total Number of Claims Paid	**281,528**	
Amount Paid to Kentucky Physicians for Blue Shield Member Services		$11,909,932
Amount Paid to Kentucky Physicians for Services Covered by Extended Benefits, Blue Cross and Blue Shield-65 and Major Medical Contracts		$2,201,850
Grand Total Paid to Kentucky Physicians		$14,111,782

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You might also say that all interns aren't alike, either.





WHAT'S NEW

in

Medical Progress

Toxemia of Pregnancy

MARVIN A. YUSSMAN, M.D.*

THE toxemias of pregnancy, a heterogeneous group of hypertensive disorders which complicate late pregnancy, continue as one of the three leading causes of maternal and fetal mortality, sharing this ignominy with hemorrhage and infection. In the United States, the incidence of toxemia varies from six per cent to eight per cent of all pregnancies, increasing with the number of indigent primigravida included in the study. Worldwide, the incidence of eclampsia varies from virtually none to three per cent of pregnancies, resulting in a maternal mortality ranging from 2.2 per cent to 12.8 per cent. In the preeclamptic form of the disease, there is a two to threefold increase in the expected perinatal loss, while the fetal mortality in eclampsia ranges from 10 per cent to 33.5 per cent.[1]

The commonly accepted classification of the toxemias of pregnancy, as redefined by the American Committee on Maternal Welfare in 1958,[2] is reproduced in Table 1. The ability to clinically differentiate these entities, however, has long been suspect. Most experienced obstetricians are aware that the classic triad of hypertension, edema and proteinuria has led to significant overdiagnosis of preeclampsia, this entity being mistaken for cases of essential hypertension and chronic renal disease.

Based on the assumption that glomerular capillary endotheliosis is a pathognomonic renal lesion in preeclampsia, a series of renal biopsies was performed by McCartney[3] in an effort to determine the actual incidence of preeclampsia in hypertensive gravid women. In 16 of 62 primigravidas, chronic renal disease was diagnosed as the etiology of the hypertension, edema and albuminuria. Three of his 62 primigravidas demonstrated no lesions, while the remaining 43 had the characteristic lesions of preeclampsia. What was more revealing, was that of 152 multigravid patients; only five could be demonstrated to have pure toxemic lesions. Sixteen had toxemia superimposed on chronic renal disease, while the remaining 131 patients were considered to have variations of essential hypertension and chronic renal disease without preeclampsia. This led to the division of the toxemias into three major categories, based on renal histology:

I. *Preeclampsia-eclampsia,* characterized by several profound biologic changes, among which is a pathognomonic renal lesion—glomerular capillary endotheliosis. These abnormalities tend to regress following delivery. Residual damage and recurrence of the entity are infrequent.

II. *Essential hypertension and chronic renal disease.* This is the dominant group in multiparous patients and patients over age 30. Pregnancy exacerbates essential hypertension, and tends to activate the hypertensive component of chronic renal disease, but does not initiate these entities. They persist following delivery and re-exacerbate in subsequent pregnancies.

III. *Chronic hypertensive vascular disease with superimposed preeclampsia.* This is the smallest category of patients. The course usually follows that of the essential hypertensive.

Relentless investigative efforts remain unsuccessful in defining the etiology of this disease. The patho-

TABLE 1
Classification of Toxemia of Pregnancy*

I	Acute toxemia of pregnancy (onset after the 24th week)
	A. Preeclampsia
	1. Mild
	2. Severe
	B. Eclampsia (convulsions or coma, usually both, when associated with hypertension, proteinuria or edema)
II	Chronic hypertensive (vascular) disease with pregnancy
	A. With superimposed toxemia (no exacerbation of hypertension or development of proteinuria)
	1. Hypertension known to have antedated pregnancy
	2. Hypertension discovered in pregnancy (before the 24th week and with postpartum persistence)
	B. With superimposed acute toxemia
III	Unclassified toxemia (data insufficient to differentiate the diagnosis)

*American Committee on Maternal Welfare

*Assistant professor, department of obstetrics and gynecology, University of Louisville School of Medicine.



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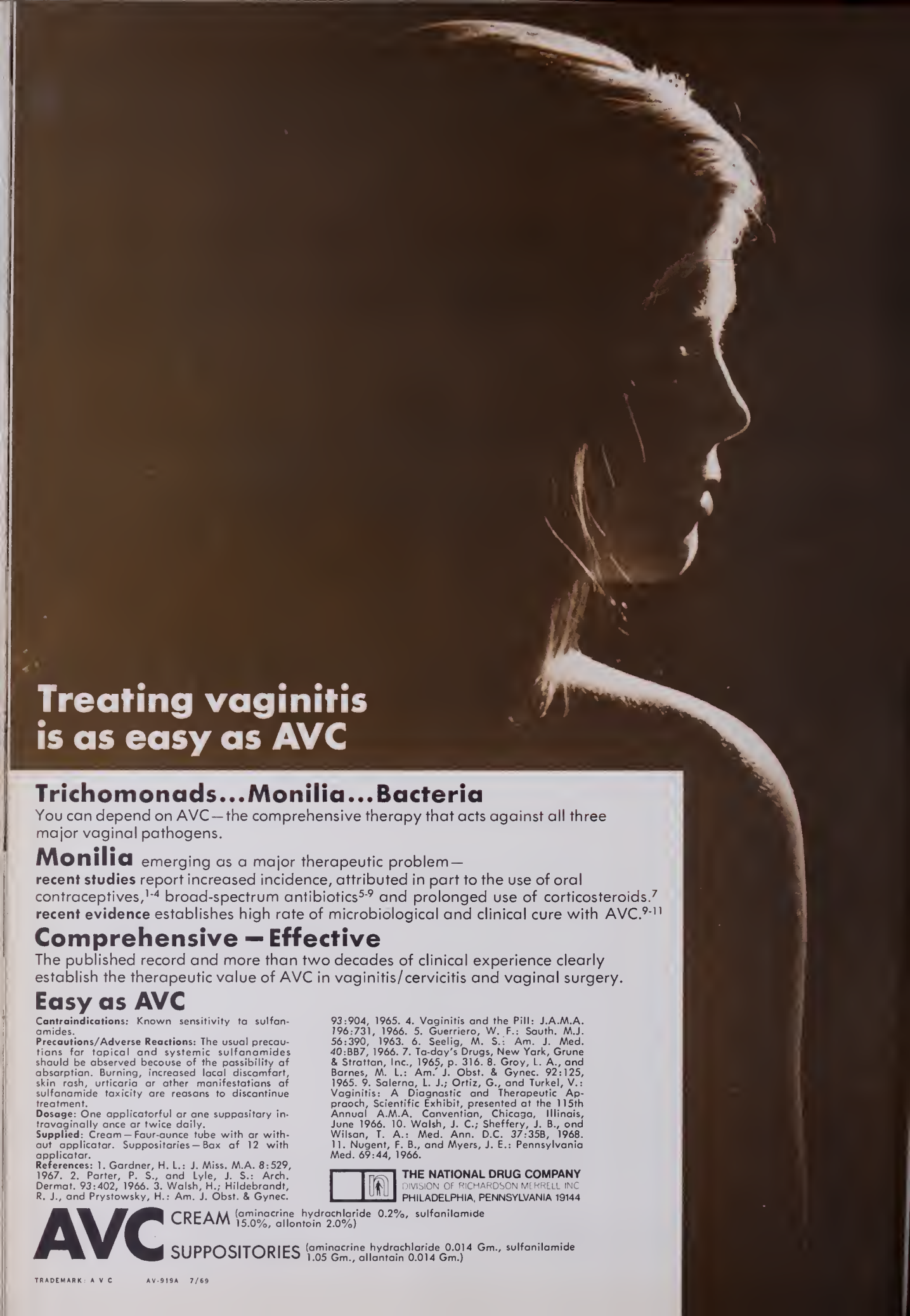
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physiology of preeclampsia, however, is presumed to revolve around sodium retention, generalized vasospasm and the resulting generalized ischemia. Though it is unknown whether these changes are primary or secondary, the early treatment of these clinical manifestations prevents the expected progression from mild to severe preeclampsia, and reverses the course of the disease. Clinical observation attests that sodium retention usually preceeds generalized vasoconstriction. Its prompt recognition, based on the observation of weight gain and edema allows for treatment of this early stage by thiazide diuretics. Such treatment has been demonstrated to be relatively ineffective once the state of generalized vasoconstriction has occurred.

Severe preeclampsia may be expected to follow rapidly if the milder form of the disease remains untreated. The severe form may be diagnosed when the blood pressure is greater than 160 systolic, the diastolic pressure is greater than 110, when there is proteinuria greater than 5 Gm/24 hours (3+-4+), when there is oliguria (less than 400 ml/24 hours), when there are cerebral or visual disturbances, pulmonary edema or cyanosis. All patients with the diagnosis of severe preeclampsia must be hospitalized. The therapy is as varied as the number of institutions reporting them. A sampling of various treatment schedules, as gathered by Zuspan,[4] is given in Table 2.

Eclampsia is treated similarly, following the initial control of convulsions. For this purpose, a variety of anticonvulsant drugs have been used. Particular attention is called to the fact that amytal sodium, a commonly used and effective anticonvulsant, can have deleterious effects when used in the eclamptic patient. Since this drug does not relieve, and may worsen vasoconstriction, it may increase cerebral anoxia and prolong coma. It may also precipitate acute pulmonary edema by further reducing compromised pulmonary function. At the University of Louisville, morphine sulfate intravenously has been used advantageously to control eclamptic convulsions (0.015 mg. is given intravenously, followed by 0.015 mg. intramuscularly as often as necessary to control convulsions, providing respirations are maintained above 12 per minute). This is augmented by the use of intramuscular magnesium sulfate, as 10 cc of a 50 per cent solution. An alternate regimen is the sole use of a continuously monitored intravenous infusion of high dosage of magnesium sulfate. In this regimen, the initial loading dose of $MgSO_4$ varies from eight to 20 gm, depending on the weight and clinical response of the patient. Maintenance dosage is provided by controlled infusion of a solution of 20 gm of $MgSO_4$ in 1000 cc of D_5W. The infusion is monitored by serum magnesium determinations, maintaining the serum level at or around six mg per cent. In lieu of serum determinations of magnesium, an infusion rate which will provide 1-1.5 gm/hour may be used empirically, providing there is adequate urinary output and that patellar reflexes can be obtained.

Other adjunctive measures are absolute quiet and accurate monitoring of urinary output and vital signs. Monitoring of central venous pressure by percutaneous catheterization of a subclavian vein allows adequate fluid replacement without danger of precipitating cardiac failure. Serial hematocrits serve as a measure of dehydration. Hypotensive agents are used only if there is reasonable concern that a cerebral vascular accident may occur as a direct result of the hypertension. Hydralazine, which increases renal plasma flow, is a particularly suitable antihypertensive for toxemic patients.

Since empiric treatment is necessary where etiology

TABLE 2

Eclamptic Treatment Regimens (after Zuspan[4])

Institution	Drug Used to Stop Convulsions	Anticonvulsant Used After Convulsions	Sedatives
Emory University	Amobarbital, iv $MgSO_4$, iv	$MgSO_4$, im	Phenobarbital, im Morphine, im
Med. Coll. Georgia	$MgSO_4$, iv	$MgSO_4$, iv	None
Med Coll. S. Carolina	$MgSO_4$, im Morphine, iv or im	$MgSO_4$, im Morphine, im	Barbiturates
Univ. Alabama	Morphine, iv Amobarbital, iv $MgSO_4$, iv or im	$MgSO_4$, im and iv	Phenobarbital
Univ. Arkansas	Barbiturates, iv	Morphine, iv Barbiturates, iv	Phenobarbital
Univ. Miami	Amobarbital, iv	$MgSO_4$, iv	Amobarbital Morphine
Univ. Mississippi	Amobarbital, iv	$MgSO_4$, iv or im	Phenobarbital
Univ. N. Carolina	$MgSO_4$, iv or im	$MgSO_4$, iv or im	Phenobarbital
State Univ. of N.Y.	$MgSO_4$, iv Pentobarbital, iv	$MgSO_4$, im	None

is undefined, a variety of ancillary drugs have been used by various institutions in the treatment of this disease. Most treatments, conscientiously applied, give comparable maternal survival. Fetal survival, however, varies. Zuspan[4] reports that the exclusion of all additional sedative medications from their intravenous magnesium sulfate regimen raised the fetal salvage at the Medical College of Georgia from 65 to 89 per cent. This increase was in neonatal survival, rather than in the stillborn rate, indicating the deleterious effect of overtreatment.

The question arises as to when to deliver the infant of a toxemic mother. In the mild preeclamptic, a variety of techniques are available for the evaluation of the intrauterine condition of the fetus. Monitoring of changes in fetal heart rate, fetal electrocardiogram and fetal acid-base status have been clinically applied with a resulting increase in fetal survival. The determination of urinary estriol excretion has not been so useful in this condition as in diabetes, but remains a valuable adjunct. One of the most promising techniques is the use of diagnostic ultrasound to determine the growth rate of the fetal skull. It was noted by Thompson, *et al.*,[5] that when the usual rate of growth of 1.8 mm/week decreased, little additional maturation could be expected. Delivery at this time prevented increasing fetal malnutrition due to placental insufficiency.

In the eclamptic or severe preeclamptic, delivery should be avoided until the disease is well controlled. If the infant is beyond 34 weeks, delivery may be accomplished from 12 hours to 48 hours after control of seizures. After 48 hours, the infant mortality rises, reaching a rate of 40 per cent after four days. It should be recognized that a deviation from normal growth occurs in the fetus of a toxemic mother. This is probably related to the demonstrable reduction in vascular flow and to villus avascularity in the toxemic placenta. The resulting fetal malnutrition affects bone growth as well as soft tissue growth. Therefore, the fetus has a low weight and height relative to its gestational age. There is also delay in the appearance of ossification centers at the knee and retardation in their subsequent growth. In an infant of a toxemic mother, little additional growth can be anticipated in the compromised intrauterine environment, and early delivery, based on gestational age rather than fetal size or epiphyseal ossification, is advisable. Amniocentesis allows fetal maturity to be confirmed by examination of the amniotic fluid for fetal fat cells, creatinine and optical density.

References

1. Haynes, D.M. In (D.M. Haynes, ed.) *Medical Complications of Pregnancy,* McGraw-Hill, New York, 1969, p. 6.

2. Eastman, N.J., Bell, E.T., Dieckman, W.J., Kellogg, F.S., Massey, R.D., Chesley, L. and Peters, J.P., Definition and Classification of Toxemias, In *The Mother,* American Committee on Maternal Welfare, 1958, p. 10.

3. McCartney, C.P. Pathological Anatomy of Acute Hypertension of Pregnancy. Circulation 29 and 30 (Suppl 2):37, 1964.

4. Zuspan, F.P. Treatment of Severe Preeclampsia and Eclampsia *Clin. Obst. & Gynec.* 9:955, 1966.

5. Thompson, H.E., Holmes, J.H., Gottesfeld, K.R. and Taylor, E.J. Fetal Development as Determined by Ultrasonic Pulse Echo Technique *Amer. J. Obstet. Gynec.* 92:44, 1965.

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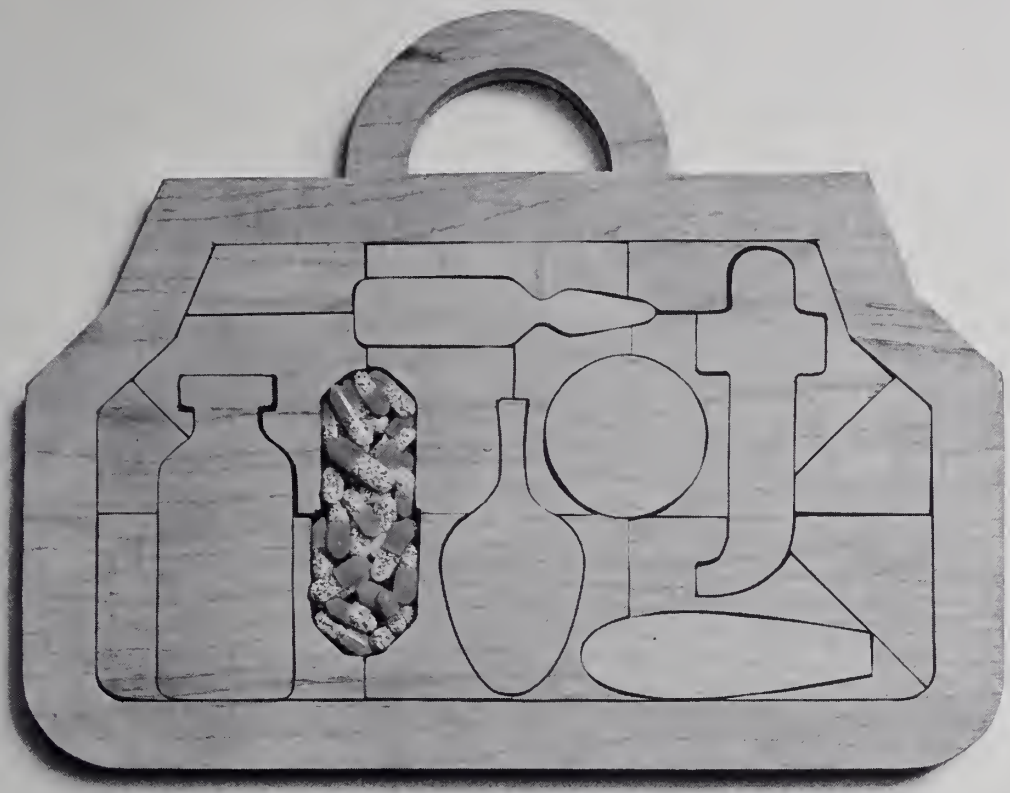
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Disastrously on Friday, March 13, the battle was brutally smashed by a power play from the Senate floor. Was it lost on the floor of the Senate? No, it was really lost back home in the May primaries and the November election. This is where the political muscles are flexed and most victories are won.

In the future, with grass root victories, more visits to Frankfort, more home phone calls, more dollars, more dedication of the physicians and Auxiliary to the organization we will see a difference and a victory.

Now let us stop to thank our friends who stood by us shoulder to shoulder in the battle:

Senator C. Gibson Downing (D), Lexington
Senator Bobby Flynn (R), Lexington
Senator Tom Garrett (D), Paducah
Senator William Gentry (D), Bardstown
Senator James A. Hicks (R), Albany
Senator Clifford B. Latta (D), Prestonsburg
Senator William A. Logan (D), Madisonville
Senator Scott Miller, Jr. (R), Louisville
Senator Delbert S. Murphy (D), Owensboro
Senator Charles Upton (R), Williamsburg
Senator Wendell Van Hoose (R), Tutor Key

A letter today to thank these men for their past support and a promise of your future assistance will be very effective if pursued.

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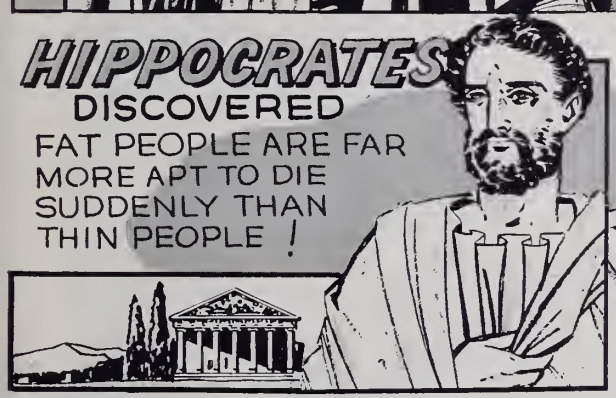
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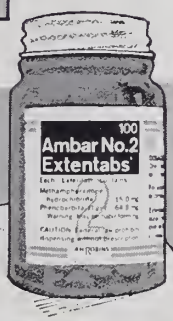


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VOLUME 68 APRIL 1970 No. 4

Blindness in Kentucky: Emphasis on Heredo-Familial Factors†

William C. Edwards, M.D.
Louisville, Kentucky

One hundred blind Kentucky children are analysed for ophthalmic diagnoses and underlying causes of blindness. Comments are made regarding the significance of retrolental fibroplasia and ectopia-lentis. The conclusion is presented that heredo-familial disease is a prominent factor in visual disability in this study.

The present study reports the results of an ophthalmological survey performed at the Kentucky School for the Blind in Louisville. The material presented describes the ophthalmic conditions and the causes of blindness in Kentucky. Of particular interest to Kentucky physicians is the emerging theme of hereditary and environmental influences in congenital and infantile visual disability. Indeed, the prevalence of inbreeding and consanguinity in certain regions of Kentucky has long been noted in the spectrum of ophthalmic problems that are evaluated at the Louisville Children's Hospital Eye Clinic by referral from organizations such as the Kentucky Commission for Handicapped Children. This experience has served as a stimulus for continued research in this field.

Although the number of congenitally blind children is small relative to the total population, they present major problems in rehabilitation and education. These children receive major supportive effort from a concerned society, as witnessed by the activities of numerous organizations. The Kentucky School for the Blind, The Kentucky Printing House for the Blind, The Kentucky Lions Club, The Commission for Handicapped Children and many private citizens and civic organizations all contribute to the education and cultural enhancement of blind children.

Methods and Procedures

The department of ophthalmology of the University of Louisville School of Medicine performed complete ophthalmological examinations on 100 consecutive children admitted to the Kentucky School for the Blind. Particular emphasis was placed on recording and investigating the family history in regard to visual problems. Information was also noted on the prenatal history, delivery, birth weights and neonatal history whenever possible. All cases were examined by the principal investigator as well as residents and medical stu-

† *From the department of ophthalmology, University of Louisville School of Medicine. This study was supported by USPHS Grant NB-05193 and HEW Grant % R01 EY 00432-02.*

Reprint Requests to William C. Edwards, M.D., Department of Ophthalmology University of Louisville, School of Medicine, 301 East Walnut Street, Louisville, Kentucky 40202.

dents working on the pediatric ophthalmology service. All 100 ophthalmic disorders were documented photographically. Interesting and/or controversial cases were presented to the ophthalmology department for review. The following legal parameters as defined in Kentucky statutes were employed to define legal blindness:

(A) A visual acuity of 20/200 or less in the better eye after correction.

(B) A visual field reduced to 10° or less on either side of fixation regardless of visual acuity.

Ninety-nine of the 100 cases were found to fit this definition. The one exception was a child who had partial restoration of her vision by cataract surgery following several years of education in the Blind School. Interestingly, this child was having difficulty returning to visual education methods and it was found necessary to continue at least part of her training by the tactile system she had already learned.

All cases were given a medical ophthalmic diagnosis. Following this, all cases were analyzed again regarding the underlying etiology such as heredity, injury, or prematurity. Five categories were selected which encompassed all of the underlying causes of blindness satisfactorily. (1) *Retinopathy of prematurity* and (2) *acquired* (such as infection or injury), are self explanatory. Another category (3) was termed *"familial"*. Cases placed in this category had an ophthalmic diagnosis of a recognized hereditary eye disease in which there were other members of the family with the same disease.



FIG. 1. Advanced case of blindness due to RLF.

The fourth (4) designation, *"genetic"*, was reserved for cases with a known hereditary ophthalmic diagnosis, in which there were no other similar cases in the immediate family. The final group (5) *"unknown"* includes cases such as congenital cataract or optic atrophy which could possibly be either familial or genetic but evidence was lacking to define the basic cause.

TABLE I

Ophthalmic Diagnoses (100 Cases) of Blindness

	No.
Retinopathy Of Prematurity	42
Retinal And Pigment Epithelial Defects	16
Tapeto-retinal and "Congenital Amaurosis" (7)	
Macular Degeneration (3)	
Cerebroretinal Degeneration (3)	
Ocular or Partial Albinism (2)	
Generalized Albinism (1)	
Optic Atrophy	9
Cause Unknown (several cases could be classified under Retina: Congenital Amaurosis) (6)	
Hydrocephalus (1)	
Craniopharyngioma (1)	
Optic Chiasm Glioma (1)	
Congenital Cataracts	8
Anophthalmos-Microphthalmos	4
Uveitis	4
Aniridia Syndrome	4
Congenital Glaucoma	3
Phthisis, Etiology Unknown	3
Retinoblastoma	2
Congenital High Myopia with Retinal Detachment	2
Trauma	2
Stevens Johnson Syndrome	1
TOTAL	100

Results

Table I lists the ophthalmic diagnoses for the 100 cases of blindness. The leading category was retinopathy of prematurity (RLF) (Fig. 1) and this was followed by congenital retinal disorders, (Fig. 2), optic atrophy, and congenital cataracts (Fig. 3). There were several cases of aniridia and various albinism syndromes. Other diagnoses included congenital chorioretinitis, "phthisis", microphthalmos, anophthalmos, retinoblastoma and trauma.

When these ophthalmic diagnoses were separated into the basic underlying causes of blindness (Fig. 4) it was found that 20 per cent of the cases were "genetic" diseases and nine cases were "familial". Only 12 per cent of the children were admitted with conditions that were acquired following birth such as infections, central nervous system disease, and trauma. A slightly larger group of 16 per cent were classified as "unknown" in regard to the underlying etiology if there were no family

history of a similar disease even though the condition could conceivably have arisen through genetic mechanisms. This group of "unknowns", includes some cases of congenital cataracts, optic atrophy, and "phthisis" which if hereditary in nature might increase the percentage of cases in that category.

Fig. 5 analyzes 42 cases of retrolental fibroplasia by birthdate and percentage of admissions born that same year. Thirty-three of these cases occurred in children born from 1951 to 1956.

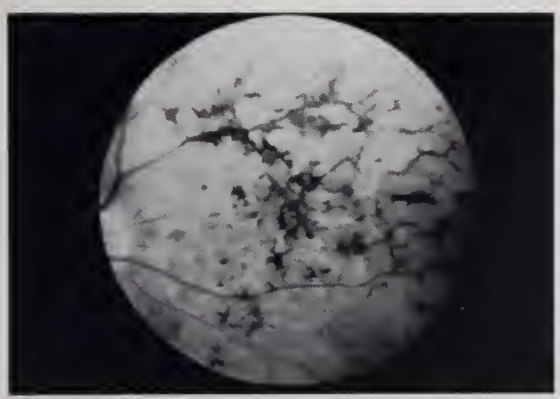


FIG. 2. Retinitis pigmentosa.

Fig. 6 shows the admissions of children with heredo-familial diseases by birthdates. The percentage of admissions due to heredo- familial causes is reduced during the years when the occurrence of retrolental fibroplasia was at its highest, however, numerical analysis shows that yearly admissions for heredo-familial disease occur at a very steady rate over the 15 year period under study. Twelve cases were born in the period from 1951-1956 and a like number from 1957-1962.

Discussion

In regard to the ocular lesions causing blindness in children our study shows many similarities to larger surveys performed in the United States, the United Kingdom, and Canada[1, 2, 3]. In all of these surveys the most common ocular lesions were retinopathy of prematurity, cataracts, chorio-retinal degenerations, optic atrophy, anirida, retinoblastoma, retinal detachment and most of the others listed in Table I of our study. In regard to the basic underlying causes of blindness our figures show a somewhat increased incidence of heredo-familial disease. The report of Robinson, et. al[3]. shows an incidence of genetic causes of blindness in children ranging from



FIG. 3. Congenital cataracts, unsuccessfully operated.

five to 11 per cent. In our study it was 29 per cent. This would tend to support the conclusion that Kentucky has a high incidence of heredo-familial eye problems and the inbreeding and consanquinity in certain areas in Kentucky are contributory factors.

In neither this study of 100 patients nor the study of Robinson et. al. (233 patients) were there any cases of legal blindness due to dislocated lenses. This is of particular interest since this is not an uncommon entity in Kentucky. There are presently 16 photographically documented cases on record in our departmental files and presumably many times that number exist elsewhere in the state. This inclines us toward the view that although this condition results in considerable visual disability, most people with ectopia lentis are educated by ordinary means or by large print. This has resulted in an extremely conservative

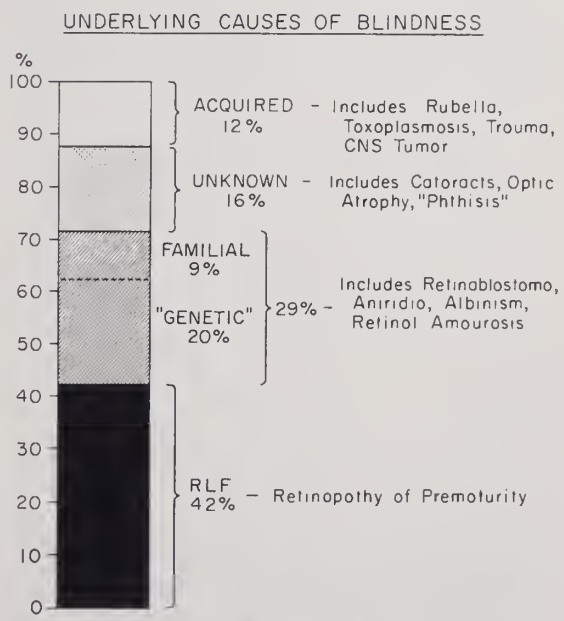


FIG. 4. Underlying causes of blindness in Kentucky (100 cases).

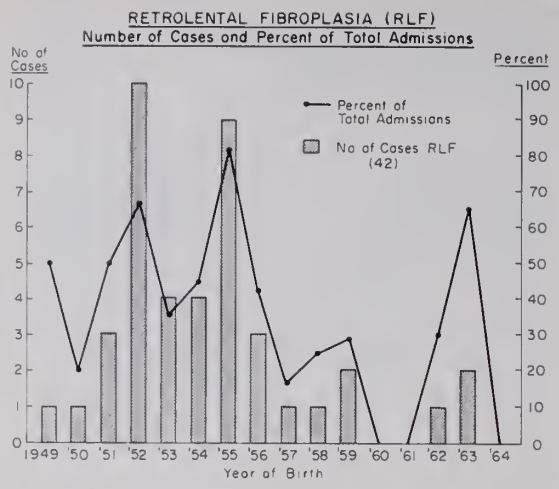


FIG. 5. Blindness due to RLF.

approach to surgery of dislocated lenses because of the unwarranted hazards involved[4]. In the text by Frazier et. al[2] concerning the causes of blindness in childhood in the United Kingdom, an analysis of the ocular lesions in 776 children listed only one case due to dislocation of the lenses.

Our chart of the incidence of retrolental fibroplasia (Fig. 5) illustrates the history of this illness quite well[5]. The peak occurrence of cases coincides with the years during which premature infants were treated with high concentrations of oxygen without full knowledge of the toxic effects of this regime. The sharp drop in cases from 1956 to 1959 reflects more restriction in the use of oxygen for premature infants and improved monitoring practice. The study of Robinson et. al,[3] shows a similar drop in cases for the period of 1950-1954 as

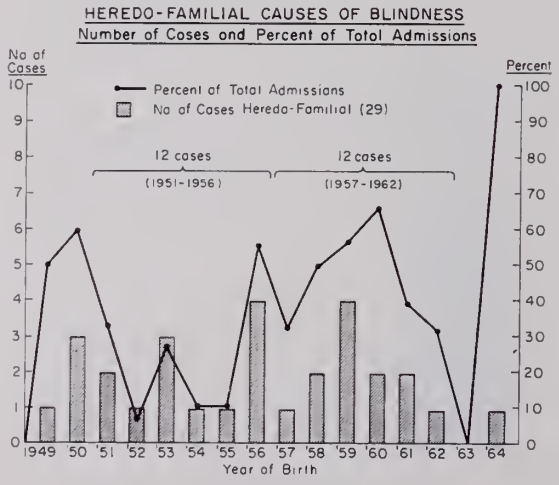


FIG. 6. Heredo-Familial cases of blindness.

compared to the period of 1955-1959. Both the studies of Robinson and the figures presented here show a slight increase in the incidence of RLF in recent years which may reflect the new awareness of the necessity for using high concentrations of oxygen in the treatment of the "respiratory distress syndrome". Of particular interest to ophthalmologists is the recent recognition of milder forms of retrolental fibroplasia such as the "dragged disc" (Fig. 7). These are being seen more frequently. Fortunately some cases are not legally blind. These milder forms of RLF could be the result of better knowledge and techniques in regulating arterial oxygen saturation in prematures.



FIG. 7. The "dragged disc" of abortive or mild retrolental fibroplasis (RLF).

Summary

One hundred consecutive admissions to Kentucky School for the Blind were analyzed in regard to environmental and etiological factors. The primary ocular lesions are listed. A basic etiological classification is also presented.

During the 15 year period studied retrolental fibroplasia was identified as a leading cause of blindness. The study placed special emphasis on the role of heredo-familial disease in blindness of Kentucky children.

Acknowledgement

We thank Mr. L. P. Howser, director, Kentucky School for the Blind and Mrs. Mary Opal Keith, chief nurse, Kentucky School for the Blind, for their enthusiastic support of this project.

We thank Mr. Thomas Van Cader for the photographs in this article.

(Continued on Page 249)

Tonsillectomy and Adenoidectomy in a Small Community Hospital

R. S. Berardi, M.D.*

McDowell, Kentucky

This paper reports on the results of tonsillectomy and adenoidectomy in a small community hospital. Data is presented from larger hospitals in order to compare results. Minimal complications, with no postoperative bleeding or deaths, are reported.

Among the 50 most frequent operations performed in general hospitals of various sizes, tonsillectomy and adenoidectomy consistently led the list[1, 2]. In our hospital, it presently ranks third coming after cholecystectomy and inguinal herniorrhapy, respectively.

In a recent computer analysis study[3], 95 per cent of patients hospitalized and operated upon for hypertrophy of the tonsils and adenoids revealed a stay of three days or less. Although the greater number of T & A's are performed under general anesthesia, one study demonstrated that 23.9 per cent were done under local anesthesia for tonsillectomy alone[4]. In a study[5] of 14 large hospitals, a comparative analysis of the T & A's performed by the "busiest" surgeon (that is, busiest in terms of doing the most T & A's) with those of all other surgeons doing T & A's in the same hospital revealed the following: The busiest surgeon performed 34 per cent of the total with an average patient age of 6.4 years. He employed antibiotics in 34 per cent of the cases and had a postoperative hemorrhage rate of one per cent. The other surgeons' category performed 66 per cent of the total, with an average patient age of 6.9 years, administering antibiotics in 52 per cent of the cases and having a postoperative hemorrhage rate of 1.3 per cent.

Since the above statistical data are indeed interesting, it was decided to study the T & A's performed in this hospital, during a five-year period, 1964-69.

General Data

During this study period, a total of 92 T & A's were performed with a sex distribution of 47 females and 45 males, having an average age of 8.5 years, with the youngest being two years and the oldest 30 years. Twenty-seven patients were over the age of 10; 26 being between the ages of 11 to 18. Two patients were less than three years old.

The average hospital stay was 2.3 days. All cases were performed under endotracheal anesthesia. With the exception of four cases (4.3 per cent), no antibiotics were employed. In these four cases an injection of 1,200,000 units of bicillin was given in two and longer term antibiotics were administered in the remaining two cases. There were neither any early nor late post-operative bleeding episodes. No deaths were recorded. In a study[6] of 294 hospitals in which over 115,000 T & A's were performed, only five deaths were recorded.

Discussion and Conclusions

Surgery of tonsils and adenoids is one of the safest procedures performed today. Complications do occur, however, most of which ensue during the healing phase. Among the complications most dreaded are postoperative bleeding, early or late, and anesthetic. It would seem that the first could be greatly minimized, if not practically eliminated, if one only adopts the philosophy that no patient leaves the operating room until absolute hemostasis is secured. In the authors' opinion, this can only be accomplished with a certain degree of security by the more liberal use of ligature sutures. This policy would also greatly lessen any chance of late (4th to 10th day) bleeding. In our series, no bleeding of any magnitude was encountered, hemostasis having been secured with the use of ligature sutures in all cases.

*Chief of surgery, Regional Medical Clinic, McDowell, Kentucky

Although the mortality rate of T & A is indeed low, this could probably be further decreased if competency in anesthesia is insisted upon. In one study[7], 40 per cent of the deaths were attributed to difficulties in anesthesia. It would seem that student anesthetists who are frequently assigned to such operations should be adequately supervised. In our series no deaths resulted, but two cases had to be abandoned because of difficulties encountered during intubation.

Endotracheal anesthesia was used in all cases in this study. Although this might not guarantee adequate pulmonary ventilation or prevent tracheal aspiration[8], chances of either adverse effect occurring would seem much less than with any other mode of delivering anesthesia.

The most significant complications occurring in this series were related to the lungs. Four cases of pneumonitis resulted, two requiring further hospitalization than the usual two days. The two abandoned cases cited above both developed pneumonia.

Although some authors[9, 10, 11] have advocated immediate tonsillectomy for quinsy, we have continued to first provide adequate drainage and then remove the tonsils electively. Dissection may be somewhat more tedious because of scarring, but healing would seem to be less complicated than operating in the presence of an abscess.

The low incidence (4.3 per cent) of antibiotic usage in this study is a striking contrast to the 34 per cent and 52 per cent cited above. We certainly have not found any higher incidence of complications. Patients are usually seen four days and three weeks after discharge from the hospital. One patient developed an acute mastoiditis two months post T & A and required surgical drainage.

Without getting involved in any lengthy discussion of the indications for T & A, suffice it to say that the more commonly accepted ones predominated in this study. However, because of a policy adopted by the United Miners Welfare Medical Board some few years ago, many in this study had some additional indication(s) along with chronic recurrent tonsillitis. Authorization for operation in any UMW patient with only a history of chronic recurrent tonsillitis is usually not granted. This is neither the place nor the moment to discuss such a policy, but we have not seen any ill effects to date following it.

In conclusion, surgery of tonsils and adenoids can result in a rather pleasant performance, devoid of serious complications, if executed with the same expertise expected in any other operation.

References

1. Cited from the Record: The 50 most frequent operations. *Commission on Professional and Hospital Activities.* Vol. 3: July, 1965.
2. Cited from the Record: The 50 most frequent operations. *Commission on Professional and Hospital Activities.* Vol 7: August, 1969.
3. Cited from the Record: Computer analysis of Length of Stay. *Commission on Professional and Hospital Activities.* Vol. 8: November, 1965.
4. Cited from the Record: Anesthesia for 50 common operations. *Commission on Professional and Hospital Activities.* Vol. 3: December, 1965.
5. Cited from the Record: T & A practice of the "busiest" surgeon. *Commission on Professional and Hospital Activities.* Vol. 3: August, 1965.
6. Cited from the Record: Death and autopsy rates for common surgical cases. *Commission on Professional and Hospital Activities.* Vol. 3: Octber, 1965.
7. Proctor, D. F.: *The Tonsils and Adenoids in Childhood.* 1st. ed.; Charles C. Thomas, Publ. Springfield, Ill., 1969,
8. Benson, C. D., et al: *Pediatric Surgery.* Vol. 1: p. 135. Year Book Medical Publisher, Inc. Chicago, 1962.
9. Bateman, G. H. and Kodicek, J.: Primary quinsy tonsillectomy. *Ann. Otol., Rhis, & Largy.* 68: 315, 1959.
10. Grahne, B.: Abscess Tonsillectomy. *Arch. Otolaryng.* 68: 332, 1958.
11. Volk, B. M. and Brandow, E. C., Jr.: Bilateral tonsillectomy for peritonsillar abscess. *Laryngoscope,* 70: 840, 1960.

The Characteristics of Court Referrals for Psychiatric Admissions

PANG L. MAN, M.D.*
Lexington, Kentucky

The typical offender would be an urban white, age between 30 and 40, with education of less than nine years, charged of violent non-acquisitive crime; diagnosis, either sociopathic personality, personality trait disturbance or alcoholism with occupation ranging from semi-skilled, unskilled to unemployed.

The association of criminality and psychiatric disorders is always difficult to determine and measure. Some aspects of the problem remain in controversy. The law and psychiatry are both interested in human behavior, with the former primarily dealing with the responsibility of the act committed. However, the latter attempts to determine whether or not the offender is psychiatrically sane. The contest between the lawyers and the psychiatrists is waged in court to find out who is mentally deranged or criminally responsible. The task is not always an easy one. A judge is empowered to order an offender to take a psychiatric evaluation, which is a wide practice across the nation.

Presented herein is a survey of 120 offenders, admitted to a state psychiatric institution for evaluation over a period of two years from May, 1967 to April 30, 1969. There were actually 134 offenders referred from the courts during this period, but we find only 120 of them with sufficient data to be included in the study. All the court cases were carefully evaluated through psychiatric interviews, social history, psychological testing and electroencephalographic studies. Our objectives were to find out the characteristics of this group of offenders and the value of the evaluation.

Clinical director, Intensive Treatment Service, Eastern State Hospital, Lexington; Clinical instructor, department of psychiatry, University of Louisville School of Medicine, Louisville

Classification of Crimes

We receive all kinds of referrals through the courts ranging from the simple offense of writing "cold checks" to the serious charge of murder. In order to study the nature of the offenses in this group of offenders, we classify them in the following categories:

1. Violent non-acquisitive: violent act but not getting anything, e.g. assault and battery, murder, malicious cutting and wounding, etc.
2. Violent acquisitive: violent act against another for possession of something, e.g. robbery with attempt to kill
3. Non-violent acquisitive: e.g., writing "cold checks" and forgery
4. Non-violent, non-acquisitive: e.g. sexual deviation, exhibitionism, etc.

Diagnostic Category

We used the official psychiatric nomenclature of the American Psychiatric Association's Diagnostic and Statistical Manual 1952. The patients primarily fell into the following categories: chronic brain syndrome, sociopath, personality trait disturbance, alcoholism, psychosis, neurosis, mental retardation and adolescent reaction.

Results

Eastern State Hospital covers a district of 40 counties which stretch from Central Kentucky to the Appalachian Mountains with a population of over one million. Lexington, a city of 180,000 people accounted for 59 court cases, about 50 per cent of the total number. Clark, Franklin and Kenton counties each sent seven cases and Scott County accounts for six cases. The above five counties had 71.6 per cent of all the court referred cases.

From Table I, we notice that sociopathic

Table I

	Number of offenders		Average age	Average schooling	Average days in hospital
Chronic Brain Syndrome	12	10%	51	7.6	83
Sociopathic Personality	48	40%	30	9.7	36.7
Personality Trait Disturbance	21	17.5%	30.3	9.6	18.5
Alcoholism	17	14.2%	41	6.7	39.2
Psychotic	13	10.8%	48	9.7	211.2
Neurotic	4	3.3%	39	10	50.5
Mental Retardation	4	3.3%	32	6	78
Adolescent Reaction	1	0.8%	17	10	16

Average schooling of the group 8.7 years

personality, personality trait disturbance and alcoholism accounted for 71.7 per cent of all the offenses whereas psychosis accounted for only 10.8 per cent. Sociopathic personality and personality trait disturbances patients' average age was 30 years but the alcohol group was about 10 years older on the average. The chronic brain syndrome, psychosis and mental retardation groups, as we can expect, were hospitalized much longer than the rest of the patients, with the psychosis being the longest (211.2 days in the hospital), but the mental retardation and chronic brain syndrome group were hospitalized about 80 days. The alcoholic patients stayed about 39.2 days mainly because the minimal stay in the Alcoholic Treatment Program is four weeks. The average schooling of the offenders was 8.7 years which is exactly the same for Kentuckians 25 years and older in the 1960 census.[1]

From Table II, according to our classification of crimes, violent non-acquisitive constitutes the majority of all the crimes (65 per cent), but violent acquisitive and non-violent acquisitive were 14.1 per cent and 16.6 per cent respectively.

Table III indicates that 46.5 per cent were married, 25 were single, and divorced and separated comprised 21.6 per cent. During the same period of 1967 the in-patient population marital status in this institution was: married, 26.2 per cent; single, 48.2 per cent, and divorced and separated, 13.3 per cent.[2] The married people in the general population in Kentucky comprise 66.1 per cent, single 22.3 per cent, separated and divorced together were 9.2 per cent (all 14 years old and older).[1] There is a significant difference between the offenders and the general population and again a marked difference between the offenders and the in-patients. The reason is that the state hospital receives all psychotics, who are usually single, especially schizophrenics.

From Table IV, we learn that the occupations of the majority of the offenders were in the semi-skilled, unskilled and unemployed groups. The figure of unemployment is very striking at 28.3 per cent with the national figure of unemployment as of November, 1969, only 3.4 per cent.[3]

The majority were white (95 persons) or 79 per cent of the total versus the Negro (25 persons) or 21 per cent. In the same period the percentage of in-patient population of the white and Negro are 88.4 per cent and 11.6 per cent respectively.[2] Comparatively speaking, there were more Negroes violating the

Table II

CRIME CLASSIFICATION

	Violent acquisitive	Violent non-acquisitive	Non-violent acquisitive	Non-violent non-acquisitive
Chronic Brain Syndrome	8%	66.6%		
Sociopathic Personality	17.4%	54.2%	21%	8.4%
Personality Trait Disturbance	14%	52%	28%	5%
Alcoholism	6%	94%		
Psychotic		90%		
Neurotic		75%		
Mental Reaction	75%			
	17 14.1%	78 65%	20 16.6%	5 4.2%

Table III

	Married	Single	Divorced	Separated	Widowed
Chronic Brain Syndrome	7		1	1	3
Sociopathic Personality	19	17	10	2	
Personality Trait Disturbance	14	5	2		
Alcoholism	8	2	4	1	1
Psychotic	6	2	2	2	2
Neurotic	2		1	1	
Mental Retardation	1	3			
Adolescent Reaction		1			
Total	57 (46.5%)	30 (25%)	20 (16.6%)	7 (5%)	6

law than the whites on a percentage basis in this study.

Discussion

From the above findings, a typical offender would be an urban white, age between 30 and 40, with education of less than nine years, with a charge of violent non-acquisitive crime; the diagnosis being either sociopathic personality, personality trait disturbance, or alcoholism; with occupation ranging from semi-skilled or unskilled, to unemployed.

Only 10.8 per cent of the total cases were psychotic, therefore theoretically 90 per cent of the cases should be responsible for the crimes committed. However, even in this small group of 10.8 per cent, some of them may be responsible for the crime committed. When some of these psychotic patients were sent to this institution for psychiatric evaluation, they had been in jail for months or weeks. It is extremely difficult to say whether or not a patient was mentally ill a few months ago, although he may be on admission. A normal person can become temporarily psychotic after prolonged confinement in isolation with sensory deprivation.[4] The patient also may have been psychotic at the time of committing the crime, but is no longer so when currently seen, e.g., a toxic psychotic or a person under extreme stress for a few days. Schizophrenia may clear up in a relatively short time, also. Then, the question of timing is very important in order to determine the individual's responsibility for a crime. The solution, we think, is for the court to appoint psychiatrists to examine any persons who commit serious crimes immediately, rather than waiting for referral.

Table IV

OCCUPATION

Housewife	3.3%	4
Unemployed	28.3%	34
Unskilled	23.3%	28
Semi-skilled	21.7%	26
Clerical	4.2%	5
Professional	3.3%	4
Student	0.8%	1
Retired	4.2%	5
Skilled	10.8%	13

Lexington and Fayette County have less than one fifth of the population covered by this insituation and yet they have 50 per cent of the referrals in this district. We speculate that (1) the hospital, being in the city, was more accessible for psychiatric service for Fayette rather than the rural counties of which 16 did not refer a single case for psychiatric evaluation over a period of two years and (2) the public and law enforcement agencies were more aware of mental illness related to crimes in Lexington.

The sociopathic personality, personality trait disturbance and alcoholic constituted 71.7 per cent of the crimes in our series. We concur with Guze et al[5] that this group of offenders are the principal psychiatric disorders found in association with criminality. However, our psychotic group (10.8 per cent) is somewhat higher than Guzes's (seven per cent) and Bromberg's (1.5 per cent).[6] It is logical and reasonable to say that over 90 per cent of the offenders would be responsible for the crime committed.

It is interesting to note that 65 per cent of the offenders are violent non-acquisitive. It seems that the majority of offenders have been aggressive and impulsive but without planning it. Our figure is higher than Silverman's.[7]

During the study period the percentage of in-patient Negro population in this institution and in the whole state was only 11.6 per cent,[2] but the Negroes who commit crimes were 21 per cent in this study.

The public usually views a violent person, in this case an offender, to be dangerous. The only well-accepted rationale for confining this "dangerous person" is to declare that he is a "mental case" and have him treated or corrected. We agree with Bromberg[8] who states: "Each member of society is unconsciously identified with aggressive, rebellious or social impulses released overtly by the psychopath. Each 'normal' member of society defends himself against the encroachment of his own unconscious aggressive impulses by projection to the person already in trouble with society. Hence, the psychopath bears the full weight of social reaction formation."

References

1. 1960 General Population Census of Kentucky.
2. Annual Statistical Report, 1967, Kentucky Department of Mental Health.
3. U. S. Labor Department, Unemployment Report, November 1969.
4. G. E. Ruff: Isolation & Sensory Deprivation, *American Handbook of Psychiatry*, Vol. III, page 362. Basic Books, 1966.
5. S. B. Guze et al: Criminality & Psychiatric Disorders. *Arch. of Gen. Psych.*, Vol. 20, No 5, page 583, May, 1969.
6. Walter Bromberg et al: The Relation of Psychosis, Mental Defect and Personality Types to Crimes. *J. Criminal Law Criminal*, 28, 70-89, 1937.
7. D. Silverman: The Psychotic Criminal, A Study of 500 cases, *J. Criminal Psychopathol.*, 8:301-327, 1946.
8. W. Bromberg: Psychopathic Personality Concept Evaluated and Re-evaluated, *Arch. of Gen. Psych.* Vol. 17, No. 6, p. 641, December, 1967.



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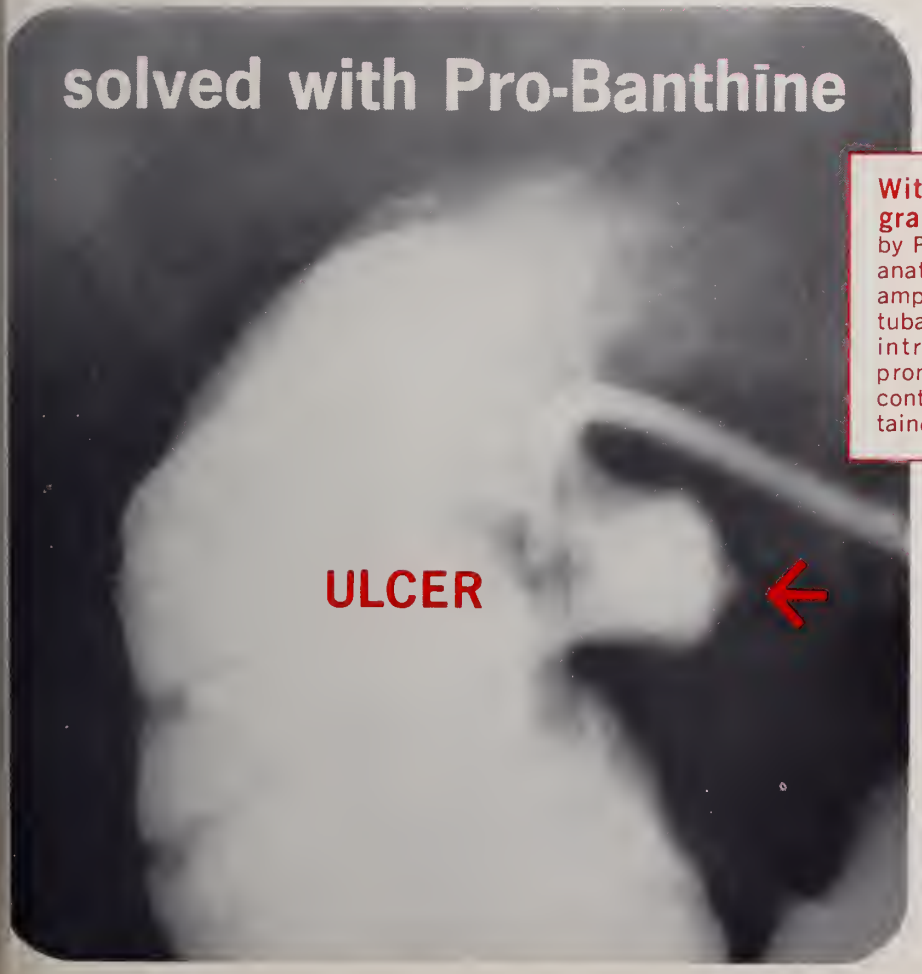
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"TB TREATMENT — HOW, WHEN, WHERE?"

9:00 - 10:30 a.m. **Treatment of TB Patients in General Hospitals**

9:00 a.m. **Pro**
Robert J. Anderson, M.D., Medical Director
American Thoracic Society
New York City

9:20 a.m. **Con**
H. Stuart Willis, M.D.
North Carolina Sanatorium System
Chapel Hill

9:40 a.m. **Audience Participation and Wrap Up**

11:00 a.m. **Tuberculosis Treatment—How?**
Norma Jean Coldiron, R.N.
Tuberculosis Project Nurse
State Department of Health

11:20 a.m. **Tuberculosis Treatment—When?**
William H. Anderson, M.D.
Professor of Medicine
Director, Pulmonary Disease Section
University of Louisville School of Medicine

Afternoon Session
"RESPIRATORY DISEASE"

2:00 p.m. **Rehabilitation of the Respiratory Cripple**
Judah L. Skolnick, M.D., Pulmonary Fellow
University of Louisville School of Medicine

2:25 p.m. **Respiratory Effects of Metabolic Alkalosis**
Thomas M. Jarboe, M.D., Pulmonary Fellow
University of Kentucky School of Medicine

2:50 p.m. **The Bag Problem**
Roger Collins, Chief Inhalation Therapist
University of Kentucky School of Medicine

3:45 p.m. **Inhalation Therapy—How, When, Where?**
Thomas V. Stephenson, M.D., Pulmonary Laboratory Director
St. Joseph Infirmary

4:15 p.m. **What Does Inhalation Therapy Do?**
Walter Rosenbalm, Chief Inhalation Therapist
Jewish Hospital

6:30 p.m. **Dinner**
Speaker to be announced

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21 Annual Southern Medical Association lectureship, "Trends in Malpractice Litigation" by Vincent Collins, M.D., L.L.B., 8 p.m., University of Kentucky Medical Center, Lexington

22 Respiratory Disease Conference, Seelbach Hotel, Louisville

23 Annual Rheumatic Disease Symposium, Louisville General Hospital's Rankin Amphitheater, Louisville

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MAY

4 PANMED television series, "Exercise and the Heart," in Louisville, WKPC-TV 10 p.m.

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7-8 Postgraduate symposium on choroidal and retinal diseases, University of Louisville School of Medicine, Louisville

8 Spring Meeting, Kentucky Thoracic Society, Kentucky Hotel, Louisville

8-9 Symposium on gastrointestinal disease, "Bring Your Own Lesion," University of Kentucky Medical Center, Lexington

11 PANMED television series, "Molar Uprighting in Preparation for Fixed Prosthodontics," in Louisville WKPC-TV 10 p.m.

12-14 Spring Meeting, Kentucky Chapter, American Academy of Pediatrics, Lookout House, Covington

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SPECIAL ARTICLES

The Doctors Feud: An Account of the Hill-Evans Affair†

David W. Kinnaird, M.D.

The Commonwealth of Kentucky has long been famous, a dubious honor, for its bloody feuds. At least 10 of these have been recorded and, some which occurred in the Eastern Kentucky mountains, are legendary[1]. Surprisingly, one of the most bloody and lengthy feuds involved two Garrard County physicians, Oliver Perry Hill, M.D. and Hezekiah Evans, M.D., their families, and allies for almost a generation.

In the latter part of the 18th century the forebears of both Doctor Hill and Doctor Evans settled in the hilly northern part of Garrard County, through which flows Sugar Creek to enter the Kentucky River. Lancaster, the county seat, founded in 1797 was six miles from the site of these settlers. In spite of the hilly terrain, the region became famous for its production of white burley tobacco and, until the advent of the railroads, an important shipping port, Quantico, was located on the Kentucky River at the mouth of Sugar Creek. Into this rustic pioneer life, Doctor Evans was born in 1801, and Doctor Hill in 1814. The Hill and Evans families, living in close proximity on small farms, were apparently on the same social and economic levels, even though other writers have questioned this conclusion[2].

It must be kept in mind that Kentucky, during the late 18th and early 19th century, was still frontierland with few roads, schools, or public institutions. As a consequence, there was a tendency for each man or family to take the law in his or its own hands and dispense justice accordingly. Most families relied on pistols and rifles for security and for meting out justice. It is recalled that whiskey was readily available to anyone and, historians agree, this led to many fights and disputes resulting in killings[3].

Doctor Evans was the eldest of many children, and following the death of his father, he assumed leadership of his family and was a successful farmer until crippled by a fall from a horse in 1829. Thereafter, he studied medicine under his younger brother and after a lengthy apprenticeship began practice in the Sugar Creek area of Garrard County. He was described as being a genuine son of Erin, a fair specimen of durability, combativeness and intelligence[4].

The younger Doctor Hill was a son of John Hill, Sr., who not only farmed, but also worked as a blacksmith. It was John Hill, Sr. who originally became involved in the Evans feud and for many years until his death in 1851 was the leader of the Hill faction. O. P. Hill, M.D. graduated from Transylvania Medical College in 1838 and began practice in the Sugar Creek area of Garrard County shortly thereafter. Though there is disagreement, most authorities consider Doctor Hill to have been an outstanding, learned and able physician[5]. It was only natural that there would exist rivalry with the older apprentice-trained Doctor Evans whom Hill often referred to as a "steam doctor", a derogatory term implying the application of steam packs for many diseases, a legacy of Indian medicine.

The troubles between the Hills and Evans began rather abruptly in 1829 and involved a negro female slave owned by the senior Hill and leased to Doctor Evans. This woman ran away from Doctor Evans and returned to the Hills' home, and it was claimed by the Hills, but denied by others, that she was mistreated by Doctor Evans and she would never under

†*Presented before the Innominate Society for Medical History, November 11, 1969, Louisville*

any circumstances return to the Evans' home. When Doctor Evans appeared and requested her return, an argument with John Hill followed, and Hill with a stave of hickory struck and knocked Doctor Evans from his horse. Mr. Hill was fined one cent in court on charges of assault pressed by Doctor Evans, and nothing further was heard regarding the slave woman. As a consequence of this affair, ill feelings between the two families were displayed openly. The removal of Doctor Evans in favor of Doctor O. P. Hill as public physician for the county poorhouse fanned the fires of professional jealousy.

Approximately 10 years after the above episode, Doctor Evans pressed a suit, considered rather unusual in those days, for an unpaid account against a prominent citizen who claimed Doctor Evans' services were not worthy of the professional fee. Doctor Hill became aligned with the defendant and testified in court that Doctor Evans had no diploma and was not competent. This flamed the smoldering fires further, and even though Doctor Evans won the suit, the animosity between the doctors and their families had entered the malignant phase! For reasons unknown at that time Doctor Hill moved his practice to Lancaster, the county seat of Garrard County.

In 1849, when emancipation of the slaves and rewriting of the Kentucky Constitution were hot political issues, Doctor Evans made the mistake of attending a political rally and barbeque at the home of some Hills who were distant cousins of the John Hill family. After considerable imbibing of whiskey by all parties, an argument ensued and Jesse Hill struck Doctor Evans with a piece of iron. The injured doctor was then stoned by the Hills and their friends. He managed to escape and sought refuge in a nearby house of a friend. The end result of this assault was a fracture of Doctor Evans' jaw, requiring several months for his convalescence.

Thereafter, this section of the county was divided into armed camps, with each family enlisting allies in their cause. The number of people and amount of arms is difficult to determine accurately, but it is believed that each family could marshal a force of 20 to 25 armed men. There were too many minor skirmishes and sieges to relate in detail; however, the following major battles are recounted briefly so as to portray the ferocity and magnitude of this feud.

On a court day in Lancaster in 1850, Doctor Evans and his sons were under surveillance by the Hill clan who were apparently spoiling for a fight. After a number of threats Jesse Hill advanced on Doctor Evans, as he was leaving the court house, and raising his gun threatened to kill him. Doctor Evans in self defense shot him two times, the last bullet piercing his heart. The Evans group escaped town before the authorities (who apparently were not too eager to become involved) could apprehend the killer. Doctor Evans refused later to surrender to the sheriff and, while the militia was being alerted, he fled to Indiana the home of his wife Nancy Cole. Several months later when things were quieter, he returned to stand trial and was acquitted.

Not quite two years had passed before the next confrontation of the feuding parties. The public square in Lancaster was the setting and the participants were two young Evans' sons, Tom and Sam, and several of the Hills. The precipitating facts are not clear. Actually, at this stage little provocation on the part of either the Hills or the Evans was needed to start a fight. At any rate, Tom Evans was cut severely in the face and hands by the Hills and was rescued by Sam Evans who shot, wounded and dispersed three Hills. For this deed, Sam Evans was acquitted. Though Tom Evans recovered, scars of his face and hands thereafter bore mute testimony to the severity of the attack.

During this same year, the most bloody battle occurred when two Evans' henchmen, John Sellers and William Chrismon, were ambushed while removing tobacco from a barn near Sugar Creek. Chrismon early sustained a fatal abdominal wound thus leaving Sellers to fight a party of five to eight Hills directed by Doctor Hill. Using a "Mississippi" rifle belonging to Doctor Evans, Sellers killed three Hills before suffering a fatal wound from the gun of young Sam Hill.

All the rules of decent, honorable combat were shelved when the bodies of Chrismon and Sellers were mutilated by their adversaries. The Hill boy was acquitted, thus continuing the pattern of legal impotency. The aroused citizenry of Lancaster called a public meeting, and a cease fire agreement was formulated only to be broken shortly thereafter when an Evans boy killed Nelson Sutherland, a Hill supporter.

The Hills did not wait long to retaliate and ambushed the Evans clan near Lancaster, fatally wounding Jesse May. The fatal shots reportedly were fired by Joseph Murphy, an ally of the Hills. This was a tragic occurrence as it was well known that this same Murphy, while badly wounded at Buena Vista in the Mexican War, was saved by Jesse May who risked his life to accomplish the deed[4].

Joseph Murphy fled the country only to return several years later setting the stage for the final violence in the feud. This deed took place when Murphy drinking in a Lancaster tavern, was surprised by two May brothers, one of whom calmly walked up and shot Murphy through the temple.

Doctor Hill, fearing for his life, refused to arrange for removal of Murphy's body and hastily left Lancaster proceeding to the West. Thus the feud came to a halt, almost as abruptly as it had begun.

Sensing defeat and the futility of the continued strife, most of the Hills departed to Washington County, Kentucky, and tradition has it that the many orphaned children and widows had difficult times for generations thereafter.

Several years later in 1855, Doctor Hill returned to Lancaster and re-established his practice. There is no factual account of any further troubles between the two families and one wonders if the beginning rumblings of the great conflict, the War Between the States, may have taken precedence over simple feuding matters. It is interesting to note that the Evans family were known to be Southern in sentiment and the Hills were Northern sympathizers.

The old adage that those who live by violence die by violence certainly holds true in this horror tale, as old Doctor Evans was robbed and assassinated while returning from a trip out of the county. There are conflicting reports as to who performed this final deed of the Evans-Hill saga, but most seem to agree, this act was unrelated to the feud. One reference relates the confession of a man named Ray on his death bed years later. A much more exciting version is the reported confession by a Confederate soldier of the robbery and murder of the Doctor Evans during the time of the Kentucky retreat of Bragg's defeated army.

At any rate, the feud wounds healed and peace returned to Garrard County with only the usual but less violent animosities between its practicing physicians.

Feuds never resolve any controversies, and there are never any victors, only losers. In this feud the Hill family lost four members and two close allies. Three of the Evans allies died but no member of the Evans family was killed during the feuding.

A survey of the recorded court indictments growing out of the feud reveals only one conviction, this being a judgement against the Hills who were fined one cent for assault. This is truly a startling indictment of the law enforcement agencies of that era.

One cannot judge the people of this time and locale too harshly. It is recalled that the citizens of this county did produce many outstanding leaders, including three governors of Kentucky. It would seem prudent to judge these terrible events as an end product of the rugged life of pioneers with slight disposition to heed the ineffectual law enforcement agencies of the times.

References

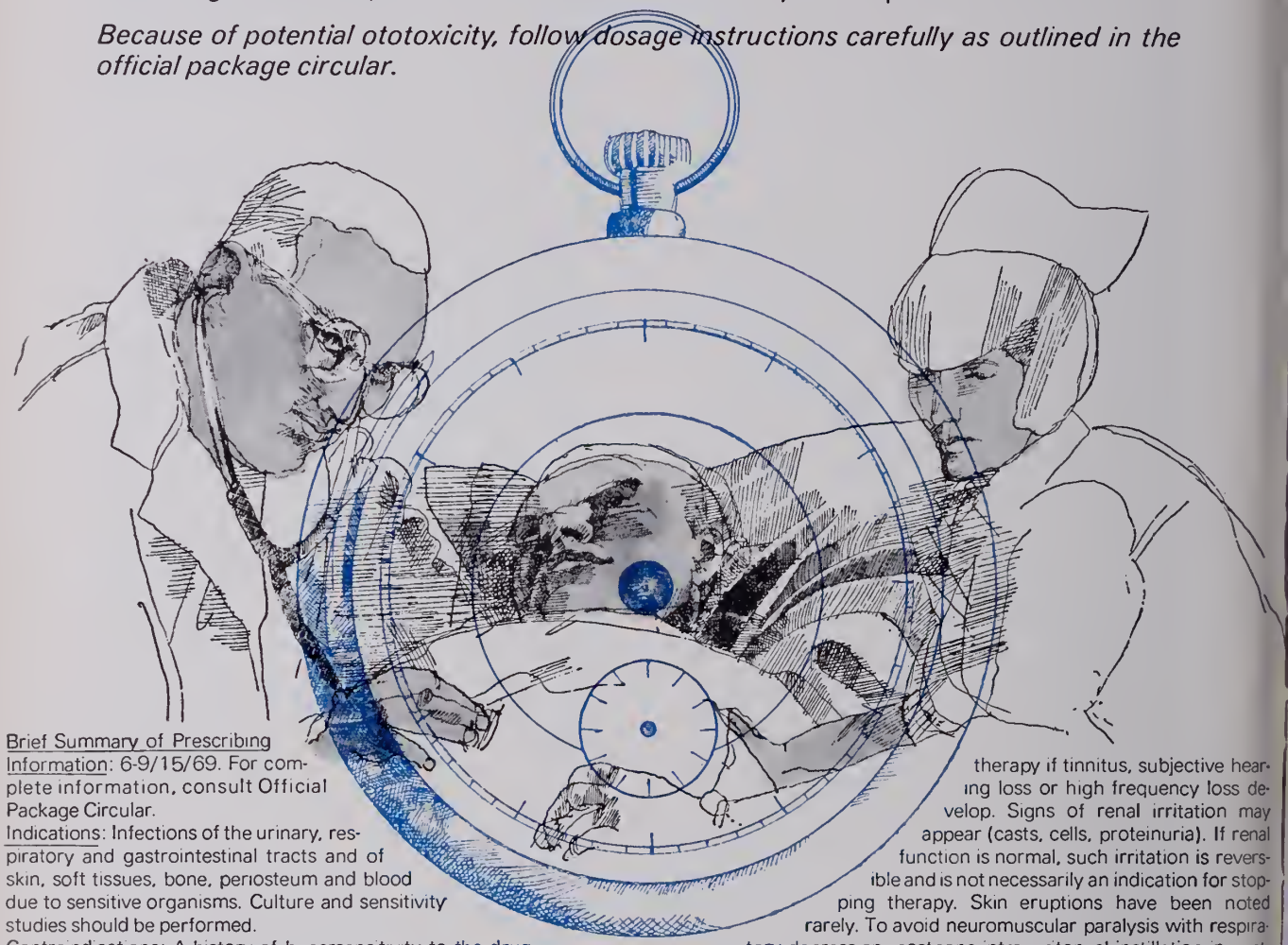
1. Coats, H. W.: *Stories of Kentucky Feuds,* Knoxville: Kingsport Press, 1940.
2. Thompson, Lt. J. J.: *The Feud Between The Hill and Evans Parties,* Cincinnati: U. P. James, 1854.
3. Calico, Forest: Personal Communication.
4. Calico, F.: *History of Garrard County, Kentucky and It's Churches,* New York: Hobson Book Press, 1947.
5. Kinnaird, J. B.: *Looking Backward*: Historical Sketches of Lancaster and Garrard County, Lancaster, Kentucky: Central Record Press, 1924.

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EDITORIALS

Actions of the General Assembly

FRIDAY evening, March 20, marked the end of the 1970 Kentucky General Assembly. It was a busy session with over 1,000 bills and resolutions introduced, more than 100 of which had to do with health matters.

Preceding this particular session, the Kentucky Medical Association developed its own legislative program. This was done in large extent by the Committee on Legislative Activities of the KMA, of which Fred C. Rainey, M.D., Elizabethtown, is Chairman for State Affairs. All of the legislative program was discussed and coordinated by the Board of Trustees. In a very large degree, it was a positive approach and did not simply represent reaction to programs that had been innovated by others.

Some of the legislation passed which KMA requested included the Uniform Anatomical Gift Act, which we would anticipate to be of great value in the field of organ transplants.

The KMA-endorsed Venereal Disease bill, which would permit treatment of minors without parental consent, was passed and is felt to be a desirable improvement of the law in that area.

The bill to merge under the State Department of Health the Tuberculosis Hospital Commission and the present Tuberculosis Control Section of the Department also received favorable action.

KMA endorsed in principle a bill which reclassifies marijuana from a narcotic drug to a dangerous drug. This is a desirable change in the law as it gives the courts an opportunity to carry out rehabilitative services for young people who may be using the drug for the first time and who obviously should not be treated as criminals.

The University of Louisville requested funds to continue the University's Kidney Dialysis Center at General Hospital, which received KMA support. This state money will permit the center to continue operation after July 1 when the major portion of its federal funds will no longer be available. A companion bill creates a state Kidney Disease Institute at the University of Louisville. As a part of the plans of this institute there will be carried out services and detection programs for kidney disease throughout Kentucky .This should be a valuable contribution to the health program of the state.

Although there are less than 500 chiropractors in the Commonwealth of Kentucky, their political strength and demands continue to be a source of amazement. During this most recent legislative session, three identical pieces of chiropractic legislation were introduced into each house. These bills would have permitted payment for chiropractic services under (1) the Kentucky Workmen's Compensation Laws; (2) Medicaid; and (3) health, disability, and comprehensive insurance policies. None of these proposals received positive action.

KMA had three separate bills that would have had an effect on the practice of chiropractic. One of these would have required all practitioners of the healing arts to be graduates of accredited professional schools. Such a bill would seem to be logical and responsible in this day of enlightenment; but for reasons which are not apparent, it failed to receive sufficient favorable action by the Legislators.

A bill which attracted considerable attention would have required that physicians be on duty and immediately accessible on a 24-hour-a-day basis in hospitals with 100 beds or more. Initially this bill passed the Senate and was reported favorably by the House, but never came to a final vote. It is obvious that with the existing shortage of physicians, it would be virtually impossible to carry out the intent of this bill. However, the introduction of such legislation does point up the problem of hospital coverage and particularly emergency room coverage in hospitals by physicians.

Every hospital should periodically review the operation of its emergency room and its emergency care system as it does all phases of hospital operation.

Another bill which received a great deal of attention in the public press was the one having to do with prescribing by generic equivalent. A good many people, including certain members of the press, grasp only the cost difference which may exist between a brand name and a generic equivalent. It is most difficult to convey to the public the problems of quality control and the fact that at the present time a physician cannot always be absolutely sure that all generic equivalents are going to have equal therapeutic potency.

Members of the KMA Committee on Legislative Activities put in many hours of their time during this past session of the legislature and represented KMA effectively. The President of KMA, the President-Elect, and the Chairman of the Board of Trustees, who comprise a policy-making "Quick Action Committee," functions during the Legislative session and allows the KMA to react immediately to changing situations. These officers gave a great deal of their time during the 60 legislative days of the General Assembly.

If the Kentucky Medical Association is to be an effective organization insofar as health matters in the state are concerned, much depends upon the physicians in the local communities. This year saw many physicians taking an interest in health legislation and demonstrating a willingness to advise and inform their Senators and Representatives. This kind of interest and effort on the local level proved of great benefit, and all Kentuckians will profit as a result.

WALTER S. COE, M.D.

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Oscar O. Miller, M. D.

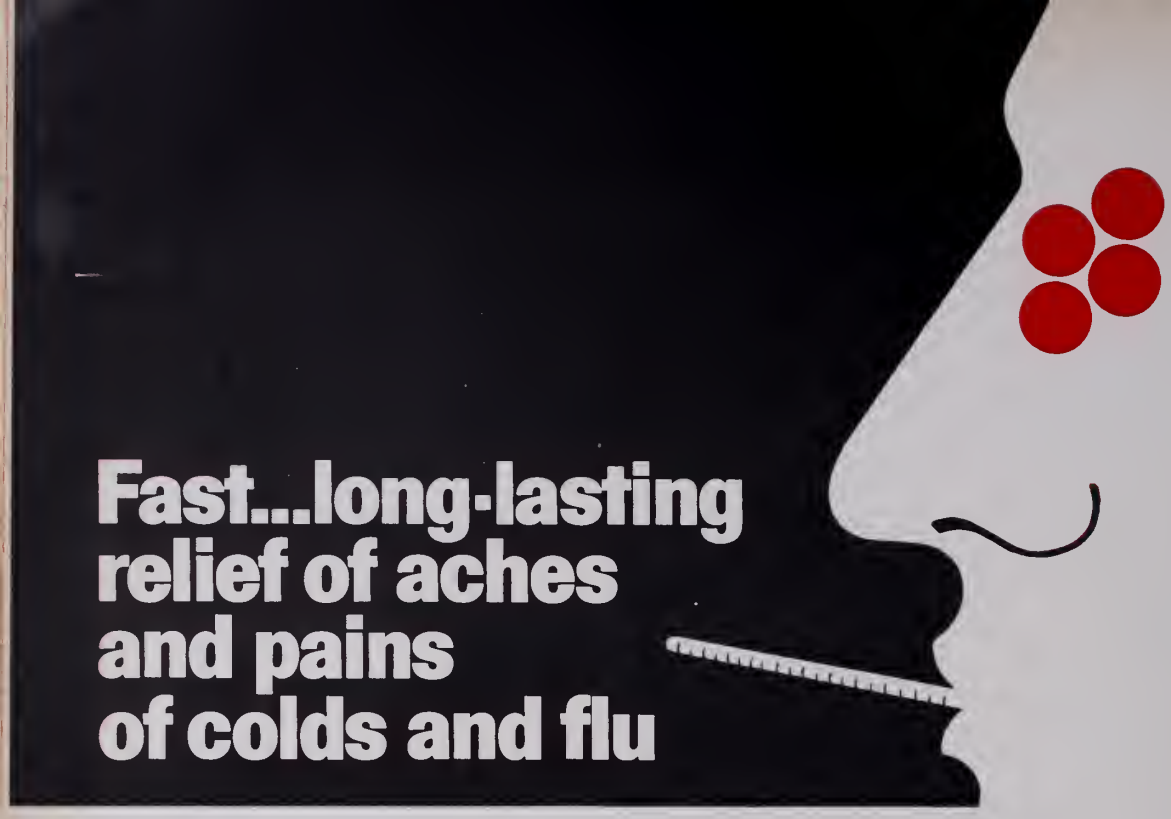
1884-1970

OSCAR O. Miller, M.D., was born in Sydney, Australia in 1884. He came to America in January of 1908, and entered the University of Louisville School of Medicine. He graduated from medical school in 1911, and became the physician in charge of Hazelwood Sanatorium, Louisville. He later became Medical Director of the Waverly Hills Sanatorium and the Waverly Hills Clinic, Louisville. In 1942 he entered private practice.

Outside of the medical profession Doctor Miller was active in the First Christian Church of Louisville where he taught for many years a Sunday School class of young married people. He was a trustee of the University of Louisville from 1950 until his death.

In his profession he served as President of the Jefferson County Medical Society in 1939 and President of the Kentucky Medical Association in 1944-1945. Doctor Miller was a professor of medicine at the University of Louisville. He was a founder of the Pre-Paid Plan, Blue Shield—in Kentucky, and was the recipient of the Kentucky State Medical Association Distinguished Service Award as well as the Distinguished Alumni Award of the University of Louisville.

Oscar Miller was a gentleman and a scholar—an articulate and eloquent speaker, a warm and friendly personality—who was held in deep affection and who was much respected by his patients, friends and colleagues.



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ORGANIZATION SECTION

Ky. Anesthesiologists To Hear ASA President On May 23

The President of the American Society of Anesthesiologists, John Steinhaus, M.D., will be a featured speaker at the spring meeting of the Kentucky Society of Anesthesiologists, May 23 in Lexington.



Doctor Steinhaus

A 1945 graduate of the University of Wisconsin, Doctor Steinhaus will speak at 8 p.m. on "Anesthesiology 1970—Where Do We Go From Here". The ASA President is professor and chairman of the department of anesthesiology, Emory University School of Medicine and has been chief of anesthesiology at Grady Memorial Hospital, Atlanta since 1958.

The scientific program of the annual meeting will begin at 1 p.m. at the Imperial House Motel, Lexington. Lexington physicians participating in the session are Donald Knapp, D.D.S., Ph.D., Robert Boettner, M.D., Preston Dilts, M.D., Marion A. Carnes, M.D. and Richard O'Neill, M.D.

Two general topics will be discussed in detail by the program participants: local anesthetics and their application in anesthetic practice, and the practical aspects of respiratory care. Two participants in the Student Research Day at the University of Kentucky College of Medicine, B. A. Bivins and Roger Morehouse, will also take part in the afternoon meeting.

Kentucky Hospital Association To Meet April 20-23

The Kentucky Hospital Association will hold its 41st Annual Convention April 20-23 at the Kentucky Hotel, Louisville. In conjunction with the Convention theme "Scanning the Seventies", Jack A. L. Hahn, president-elect of the American Hospital Association, will speak at the opening session on "A Decade for Daring". Mr. Hahn is President of the Methodist Hospital of Indiana in Indianapolis.

Brian J. Shea, M.D., director-general of medical services for South Australia, will be the featured speaker at the annual President's Luncheon. Doctor Shea will discuss pertinent aspects of health care delivery in Australia.

The four-day meeting will also feature educational sessions, the annual banquet, exhibits and meetings of allied groups. Chalmer H. Frazier, Prestonsburg, will be installed as President of KHA and Elmer L. Crozier, past president, and other 1969-70 officers will be honored at the annual banquet.

Vance Packard To Address 19th KAGP Annual Mtg.

Vance Packard, internationally recognized author and social critic, will be the luncheon speaker for the 19th Annual Meeting and Scientific Assembly of the Kentucky Academy of General Practice held May 5-8 at Convention Center and the Seelbach Hotel, Louisville.



Mr. Packard

The author of many best-sellers, including "The Hidden Persuaders" and "The Status Seekers", Mr. Packard will deliver the luncheon address, Wednesday, May 6. His topic will be "The Bewildered Sexes".

Included among the other prominent guest speakers for the three-day scientific assembly will be Donn L. Smith, M.D., Tampa, Fla., a former dean of the University of Louisville School of Medicine. Doctor Smith, who is now dean of a medical school being built at the University of South Florida, will discuss the family practice programs and their significance to modern medical education.

Participants on various panels will deal with such topics as treatment of acute strokes, continuing education and obesity. Guest speakers from Kentucky and throughout the country will address the Academy on hypertension and hypokalemia, coronary care, rubella-vaccine and poisonous snakes.

The session will also include a meeting of the Congress of Delegates of KAGP and the installation of officers on Wednesday evening, May 6.

KMA INTERIM MEETING

Since the 1970 KMA Interim Meeting took place at press time, The Journal was unable to carry details in this issue. Complete information, including pictorial coverage, will appear in the May issue.



John H. Leland, M.D., Crestwood, is shown presenting the Kentucky Medical Association Safety Award to Chief Milton C. Sloess of the South Oldham Fire Department Rescue Squad at the Crestwood Fire Station. The award was in recognition of the group's leadership, thoughtful planning and their example of active concern for the safety of the people.

So. Oldham County Rescue Squad Receive Ist KMA Safety Award

The first KMA Safety Award was presented to the South Oldham Fire Department and Rescue Squad on February 2. The new award, established in 1969, was designed for presentation to individuals or organizations who have rendered outstanding leadership and planning toward the safety and protection of the citizens of Kentucky.

A volunteer organization, the South Oldham Fire Department has an effective and fully equipped rescue squad, due in part to the efforts of the South Oldham Lions Club. The Fire Department and Rescue Squad have rendered life saving aid in hundreds of emergencies of every description. New modern equipment was just recently purchased to increase the squad's capabilities.

KMA members are urged to forward nominations for this award for organiztaions in their community to the KMA Headquarters Office.

New AMA Department Established To Strengthen Specialty Ties

The Department of Specialty Society Services was established on January 22 by the American Medical Association to strengthen liaison and services to related medical organizations. Theodore R. Chilcoat, Jr., former assistant director of the AMA Department of Governmental Relations, is director of the new department, which will report directly to Richard S. Wilbur, M.D., assistant executive vice-president.

The responsibilities of the Department will be to serve and implement the directives of the Interspecialty Committee which was created in 1966. Ernest B. Howard, M.D., AMA executive vice-president, announced on January 22 that Doctor Wilbur was appointed secretary of the Committee.

Doctor Howard said, "The establishment of this special department is an important step in strengthening AMA's relationship with the specialty societies, and it is the culmination of a long range program undertaken to upgrade the services of the AMA to the specialty societies."

TB Treatment To Be Discussed At Thoracic Society Mtg., May 8

"Tuberculosis Treatment — How, When, Where?" will be one of the various topics discussed at the spring meeting of the Kentucky Thoracic Society set for Friday, May 8, at the Kentucky Hotel, Louisville, according to Richard B. McElvein, M.D., Lexington, program chairman.

Discussing the "pro's" and "con's" of treating TB in general hospitals will be Robert J. Anderson, M.D., medical director of the American Thoracic Society, and H. Stuart Willis of the North Carolina Sanatorium system.

These and other discussions on TB and its treatment are scheduled from 9 to 12 noon. The afternoon sessions, beginning at 2 p.m., will deal with "Rehabilitation of the Respiratory Cripple" and the "Respiratory Effects of Metabolic Alkalosis." Discussions of inhalation therapy also are scheduled for the afternoon session. Complete details of the program are on page 235.

Respiratory Disease Conference Set

A Respiratory Disease Conference for Health Professionals has been scheduled in conjunction with the annual meeting of the Kentucky Hospital Association. The Conference will begin at 8:30 a.m. April 22 at the Seelbach Hotel, Louisville.

Participants in the one-day program include Miss Virginia Bloch, R.N., Visiting Nurses Association, Richmond, Thomas V. Stephenson, M.D., Gerald E. Vallee, M.D., Emery E. Lane, M.D., and William H. Anderson, M.D., all of Louisville. Following the presentations a movie on "Care and Feeding of IPPB Apparatus" will be shown.

Med. Students Want Summer Jobs

Medical students at the University of Louisville have related to the editors of *The Journal* their interest in obtaining health-related work during summer vacation. Anyone knowing of any opportunities along these lines should contact the Jefferson County Medical Society, Medical Arts Building, Louisville, 40217.

Alberto Mazzoleni, M.D., Lexington, and **Donald H. Mosley, M.D.,** Louisville, were recently granted a Fellowship in the American College of Cardiology.

Ky. Pediatricians Schedule Spring Meeting May 12-14

The 12th Annual Spring Meeting of the Kentucky Chapter, American Academy of Pediatrics will be held May 12-14 in the Northern Kentucky area, according to Frederick A. Stine, M.D., Ft. Thomas, program chairman.

The scientific sessions of the three-day session will be held at the Lookout House, Covington. Guest speakers on the program include Sylvia Richardson, M.D., University of Cincinnati, speaking on "Learning Disorders in the Normal Child" and Harold Fogelson, M.D., University of Cincinnati, dealing with the management and treatment of convulsive disorders.

David B. Clark, M.D., chairman, department of neurology, University of Kentucky Medical Center, will address the group on "Subtle Neurologic Convulsive Disorders".

Ky. OB-GYN, Cancer Society Plan Mtg., Symposium May 15-16

The 22nd Annual Meeting of the Kentucky Obstetrical and Gynecological Society will be held May 15-16 at the Brown Hotel, Louisville. The Kentucky Division of the American Cancer Society will also sponsor this meeting.

A symposium on gynecological cancer, which will compose the May 15 program, will feature four nationally-known speakers. The four participants are Donald J. Woodruff, M.D., professor of gynecology and obstetrics at Johns Hopkins University, Baltimore, Md.; Professor Stanley Way, Newcastle-on-Tyne, England; James Krieger, M.D., chief of gynecologic service, Cleveland Clinic, Cleveland; and John L. Lewis, Jr., M.D., chief of gynecologic service, Memorial Hospital, New York City.

Topics for discussion include the field theory of squamous carcinomas in the female, trophoblastic and ovarian tumors and chemotheraphy in gynecologic malignancies.

Ky. Surgical Society Schedules Annual Meeting May 15-16

The Kentucky Surgical Society will hold its annual meeting May 15-16 at Kentucky Dam Village State Park, Gilbertsville. Participating in the two-day session will be Kenneth W. Warren, M.D., chairman of the department of general surgery of the Lahey Clinic Foundation, Boston, and Harry C. Hull, M.D., professor of Clinical surgery, University of Maryland School of Medicine.

Doctor Warren will be discussing "The Surgical Management of Chronic Relapsing Pancreatitis and Periampullary Tumors" and "A Long-Range View of the Surgical Repair of Common Duct Strictures."

On the evening of May 15, Doctor Hull will address the members, their guests and wives on the subject "Emperor Smith." Other papers will be presented by members of the Society.

KSAMA Annual Mtg. Is May 15-17

The Kentucky State Association of Medical Assistants have scheduled their Eighth Annual Convention May 15-17 at Stouffer's Inn, Louisville, according to Miss Dorothy Downs, and Mrs. Virginia Applegate, both of Louisville, who are co-chairmen of the program committee.

"Progress Through Education" is the theme for the three-day session, which will begin on Friday evening with a hospitality welcome, continue with the education program on Saturday and conclude with a business session on Sunday. Details of the meeting will be sent to all members.

Blindness in Kentucky

(Continued from Page 224)

References

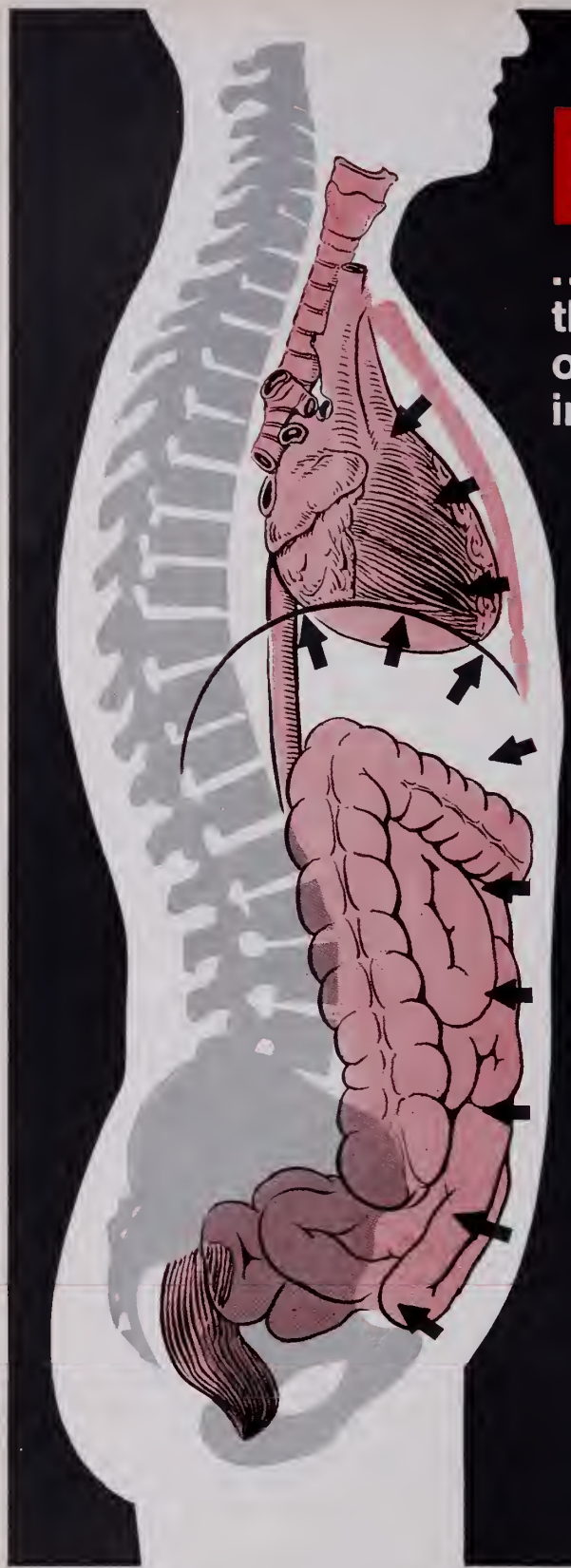
1. Hatfield, A.E.: *Sightsaving Review* 33:218 1963.
2. Fraser, G. R. and Friedman, R. I.: *The Causes of Blindness in Children*. Johns Hopkins Press, Baltimore, 1967.
3. Robinson, G.C., Watt, J.A., and Scott, E.S.: A Study of Congenital Blindness in British Columbia. *Canad. Med Association Journal* 99:831-836 November 1968.
4. Maumee, A.E. and Ryan, Stephen J.: Aspiration Techniques for Dislocated Lens; *Amer. J. Ophth.* Vol. 68:808 November 1969.
5. Patz, A.: *Retrolental Fibroplasia.* Survey of Ophthalmology. 14:1-29 1969

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*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice,* 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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KMA Lists 1970 Officers Of County Societies

In addition to the officers listed in the March *Journal,* the following list of county medical society officers had been received by KMA as of March 19, according to the records of the membership department.

Allen
President: Owen L. Davis, M.D., Scottsville
Vice President: Francis H. Halcomb, M.D., Scottsville
Secretary-Treasurer: John M. Hall, M.D., Scottsville
Delegate to KMA: Earl P. Oliver, M.D., Scottsville
Alternate: John M. Hall, M.D., Scottsville

Cumberland
President: James W. Morris, M.D., Burkesville
Secretary: Joseph Schickel, M.D., Burkesville
Delegate to KMA: James W. Morris, M.D., Burkesville
Alternate: Joseph Schickel, M.D., Burkesville

Fayette
President: Richard B. McElvein, M.D., Lexington
Vice President: Peter P. Bosomworth, M.D., Lexington
President-Elect: Leslie W. Blakey, M.D., Lexington
Secretary-Treasurer: Porter Mayo, M.D., Lexington
Delegates to KMA: Richard D. Floyd, M.D., Lexington
Richard F. Hench, M.D., Lexington
David A. Hull, M.D., Lexington
Bush A. Hunter, M.D., Lexington
Carl H. Scott, M.D., Lexington
Ben C. Stigall, M.D., Lexington
John F. Berry, Jr., M.D., Lexington
Peter P. Bosomworth, M.D., Lexington
N. Lewis Bosworth, M.D., Lexington
T. R. Bryant, M.D., Lexington
W. L. Burke, M.D., Lexington
Donald E. Edger, M.D., Lexington
Richard B. McElvein, M.D., Lexington
Leslie W. Blakey, M.D., Lexington
Alternates: L. Chase Allen, M.D., Lexington
Ted D. Ballard, M.D., Lexington
Robert C. Burkhart, M.D., Lexington
Porter Mayo, M.D., Lexington
Charles Nicholson, M.D., Lexington

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President: Thomas H. Baker, Jr., M.D., Frankfort
Secretary-Treasurer: William H. Keller, M.D., Frankfort
Delegate to KMA: S. L. Weiler, M.D., Frankfort
Alternate: William H. Keller, M.D., Frankfort

Garrard
President: O. S. Playforth, M.D., Lancaster
Vice President: Paul J. Sides, M.D., Lancaster
Secretary-Treasurer: Paul J. Sides, M.D., Lancaster
Delegate to KMA: Paul J. Sides, M.D., Lancaster
Alternate: O. S. Playforth, M.D., Lancaster

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President: J. Steele Robbins, M.D., Mayfield
Vice President: Donald C. Haugh, M.D., Mayfield
Secretary-Treasurer: C. E. Howard, M.D., Mayfield
Delegate to KMA: C. Douglas LeNeave, M.D., Mayfield
Alternate: Larry L. Hall, M.D., Mayfield

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President: A. L. Embry, M.D., Millwood
Vice President: Ray A. Cave, M.D., Leitchfield
Secretary-Treasurer: Ralph G. Thomas, M.D., Leitchfield
Delegate to KMA: Charles L. Bland, M.D., Leitchfield
Alternate: J. R. Buckles, M.D., Caneyville

Hardin
President: Wreno M. Hall, M.D., Elizabethtown
Vice President: Bernard Greenwell, M.D., Elizabethtown
Secretary-Treasurer: William Handley, M.D., Elizabethtown
Delegates to KMA: Robert E. Robbins, M.D., Elizabethtown
Fred C. Rainey, M.D., Elizabethtown
Alternates: Clyde M. Brassfield, M.D., Elizabethtown
William A. Barnard, M.D., Elizabethtown

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Vice President: Joe A. Nichols, M.D., Cynthiana
Secretary-Treasurer: Wilbur H. Wilson, M.D., Cynthiana
Delegate to KMA: Don R. Stephens, M.D., Cynthiana
Alternate: Wilbur H. Wilson, M.D., Cynthiana

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President: D. G. Barker, M.D., Hindman
Vice President: Gene T. Watts, M.D., Hindman
President-Elect: Gene T. Watts, M.D., Hindman
Secretary-Treasurer: Gene T. Watts, M.D., Hindman
Delegate to KMA: D. G. Barker, M.D., Hindman
Alternate: Gene T. Watts, M.D., Hindman

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Vice President: R. E. Dodge, Jr., M.D., Hyden
Secretary: W. B. R. Beasley, M.D., Hyden
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Alternate: R. E. Dodge, Jr., M.D., Hyden

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Vice President: Charles Harris, M.D., Berea
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Delegate to KMA: Robert L. Rice, M.D., Richmond
Alternate: Glynn Reynolds, M.D., Richmond

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Secretary: L. P. Emberton, M.D., Edmonton
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President: Morris L. Peyton, M.D., West Liberty
Vice President: George Bellamy, M.D., West Liberty
Secretary: Alec Spencer, M.D., West Liberty
Delegate to KMA: Morris L. Peyton, M.D., West Liberty
Alternate: Alex Spencer, M.D., West Liberty

Community Health Week In Kentucky, May 3-9

Community Health Week in Kentucky will be observed May 3-9, according to John M. Baird, M.D., Danville, chairman of the KMA Committee on Community and Rural Health. The committee has completed its plans for Community Health Week, which includes a request for an official proclamation by Governor Louie B. Nunn. Other state organizations will be asked to join KMA in urging all Kentuckians to become involved in activities to promote their physical well being through comprehensive physical fitness programs.

Doctor Baird urges all KMA members and allied groups to take an active part in Community Health Week by displaying special posters promoting this event and by explaining the benefits of fitness for adult health.

"Personal fitness" he noted, "will aid in the good health of all citizens, especially the middle-aged, out-of-condition persons who are 'too busy to exercise.' " He stressed that physical fitness must be a year-round program, and that not only school-age children, but adults as well, should become involved in programs to better their physical condition.

Doctor Baird also pointed out that Community Health Week is being promoted this year in place of Immunization Week to focus public awareness of the efforts of all members of the health team striving to better the health of the Commonwealth's citizens.

Correction

A correction is indicated for the "Answers to Your Questions About Blue Shield" which appeared in the February issue of The Journal. The identification numbers for Blue Cross and Blue Shield members having the Extended Benefits Endorsement are as follows: the "40" code indicates Extended Benefits Endorsement on a Single Basis; the "50" code indicates Extended Benefits Endorsement on a Family Basis.

Maternal Mortality

(Continued from Page 205)

The association of thymic tumor and blood dyscrasia has been documented. This rare combination has been of great interest to several investigators. Havard and Scott[2] have reported three patients in whom erythroblastic aplasia of the bone marrow accompanied a thymoma. In their review of the literature 29 instances were found.

Josse and Zacks[3] report a case of thymoma and pancytopenia. In their review of the literature 15 cases were found to represent the coexistence of primary thymic tumor and blood dyscrasia.

The antibiotic therapy was reviewed by the Committee (possibly other agents would have been more effective), however the ultimate prognosis for this patient appeared hopeless.

References

1. Iverson, L.: Thymoma—A Review and Reclassification. *Am. J. Path.* 32:695, 1956
2. Havard, C. W. H., and Scott, R. B.: Thymic Tumor and Erythroblastic Aplasia. *Brit. J. of Haematology.* 6:178, 1960.
3. Josse, J. W., and Zacks, S. I.: Thymoma and Pancytopenia. *New Eng. J. Med* 259:113, 1958.

Insurance Page

(Continued from Page 209)

the private hospitals. This implied that good records are not necessarily the mark of a good physician. The young resident further stated that he did not plan to waste any time writing records when he got into private practice. This may be one of the key faults in the system. The respected leaders in the profession do not set the best example for the younger generation.

LEWIS DICKINSON, M.D.

J. Murray Kinsman, M.D., Louisville, will be elevated to Master in the American College of Physicians during the College's Annual Convocation, April 12-17 in Philadelphia.

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For preoperative preparation, a combination of tablets at night and a suppository the next morning usually cleans the bowel thoroughly.

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*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

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MAY 27, 28, 29, 1970

MEMPHIS **TENNESSEE**

Opportunities Available to General Practitioners Through KMA Physicians Placement Service

The Physicians Placement Service of the Kentucky Medical Association, in an effort to obtain a better distribution of physicians in our state, is listing below the many practice opportunities available for general practitioners, and would encourage any physician desiring to relocate his practice to contact KMA's Physicians Placement Service for detailed information on any opportunity listed below.

We do our best to provide a two-way flow of information between interested parties without actually recommending or becoming involved in any negotiations.

This list includes three breakdowns: one indicating communities where local citizens are hoping to encourage a doctor to establish a practice in their area; general practitioners in the rural area in need of replacements; and physicians desiring association. This last section includes opportunities for partnership, or in group practices, quite often with no investment necessary and offering a specified minimum salary in the beginning.

If you are interested in any particular area, please let us know, and we will be happy to provide additional details.

COMMUNITIES SEEKING PHYSICIANS

General Practitioners

County	City	County	City
Clinton	Albany	Logan	Auburn
Greenup	Raceland	McCracken	Reidland
Greenup	Russell	Marshall	Hardin
Harlan	Evarts	Ohio	Fordsville
Hart	Horse Cave	Owen	Owenton
Knox	Barbourville	Pendleton	Falmouth
Larue	Hodgenville	Shelby	Shelbyville
Logan	Adairville	Webster	Sebree

PHYSICIANS DESIRING REPLACEMENTS

General Practitioners

County	City	County	City
Garrard	Lancaster	Muhlenberg	Central City
Graves	Mayfield	Nelson	Bloomfield
Jessamine	Nicholasville	Pendleton	Falmouth
Lincoln	Stanford	Shelby	Shelbyville
Mason	Maysville	Trigg	Cadiz

PHYSICIANS DESIRING ASSOCIATES

General Practitioners

County	City	County	City
Adair	Columbia	Hopkins	Madisonville
Barren	Glasgow	Laurel	London
Bell	Middlesboro	Letcher	Whitesburg
Bourbon	Paris	Livingston	Salem
Bullitt	Shepherdsville	McLean	Calhoun
Caldwell	Princeton	Madison	Berea
Calloway	Murray	Madison	Richmond
Christian	Hopkinsville	Muhlenberg	Greenville
Daviess	Owensboro	Oldham	LaGrange
Edmonson	Brownsville	Perry	Hazard
Floyd	McDowell	Pike	Pikeville
Greenup	South Shore	Pulaski	Somerset
Hardin	Elizabethtown	Russell	Jamestown
Harlan	Harlan	Webster	Providence
Henderson	Henderson		

Roy Suyemoto, M.D., a pathologist, is now practicing with George Tanner, M.D., Ft. Thomas. Doctor Suyemoto graduated from the University of Cincinnati in 1962 and then took his internship and residency at Cincinnati General Hospital. An instructor at the University of Cincinnati Medical Center, Doctor Suyemoto is a Fellow of the American Society of Clinical Pathologists.

Lincoln Mario de Souza, M.D., a urologist, is practicing at the Daniel Boone Clinic, Harlan. A 1954 graduate of the University of Minas Gerais, Brazil, Doctor de Souza completed his internship at Deaconess Hospital, St. Louis and took his residency in urology at Wilkes-Barre General Hospital, Pennsylvania. Before coming to America, Doctor de Souza practiced medicine in Brazil from 1955-1963.

In Memoriam

HERBERT GRAHAM DAVIS, M.D.
Marrowbone
1874-1969

Herbert Graham Davis, M.D., 95, died December 31. An emeritus member of KMA, Doctor Davis retired in 1960 after more than 50 years of general practice at Marrowbone. A 1903 graduate of Louisville Hospital College of Medicine, Doctor Davis was a member of the Southern Medical Association, as well as the American, Kentucky, and Cumberland County medical associations.

THOMAS B. COLEMAN, M.D.
Louisville
1907-1970

Thomas Benton Coleman, M.D., 62, who practiced general medicine in Louisville for more than 30 years, died February 13. A 1932 graduate of the University of Louisville School of Medicine, Doctor Coleman served as a battalion surgeon for the 776th Tank Battalion through the invasion of Okinawa.

JOHN W. PRICE, JR., M.D.
Louisville
1882-1970

John W. Price, Jr., M.D., 88, a retired Louisville surgeon, died February 25 in Delray Beach, Florida. A graduate of the University of Pennsylvania Medical School, Doctor Price became a pioneer in surgical research after joining the University of Louisville School of Medicine in 1908.

He founded the Surgical Research Laboratory at U of L and established a trust fund there in 1957. Doctor Price performed the first operation in Kentucky on the pituitary gland in 1912, and invented a tube for use in end-to-end sewing of blood vessels.

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LAWRENCE U. GILLIAM, M.D.
Corbin
1920-1970

Lawrence Ullis Gilliam, M.D., 51, died February 25, in Corbin. A 1950 graduate of the University of Louisville School of Medicine, Doctor Gilliam specialized in pediatrics. An active member of KMA, Doctor Gilliam was a member of the Technical Advisory Committee on Physician Services (Title XIX).

EUGENE TODD, JR., M.D.
Lexington
1916-1970

Eugene Todd, Jr., M.D., died February 22 at the age of 54. A 1942 graduate of the University of Louisville School of Medicine, Doctor Todd practiced surgery in Lexington. He was a member of the Kentucky and American medical associations.

KMA Committee Reports

KMA Committee on School Health, Physical Education and the Medical Aspects of Sports
O. B. Murphy, M.D., Lexington, Chairman

KMA Headquarters Office **February 12, 1970**

The KMA Committee on School Health, Physical Education and the Medical Aspects of Sports held their first meeting of the Associational year recently. One of the main items of discussion concerned the preparation of an exhibit which is presented by the committee each year at the Annual Meeting of the Kentucky Education Association.

Other agenda items included methods of strengthening liaison between physicians and health educators and the status of drug abuse in Kentucky. Future plans of the committee include the presentation of the pre-season medical aspects of sports seminars next fall.

KMA Health Careers Committee
Joseph Hamburg, M.D., Lexington, Chairman

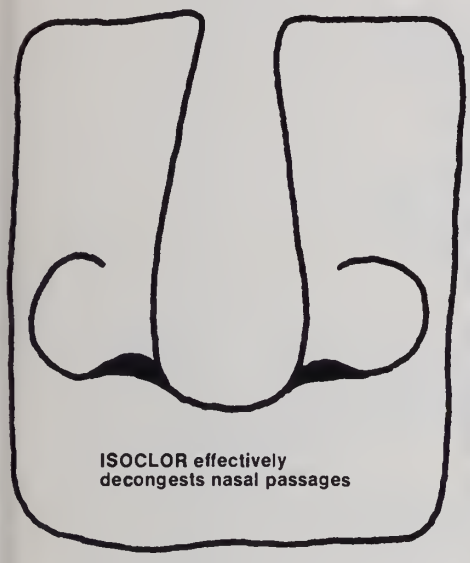
KMA Headquarters Office **February 26, 1970**

The KMA Health Careers Committee met recently at the Headquarters Office. One of the major items of discussion centered on the implementation of the new additional duties of the committee which are to evaluate, assist and bring before the Board any paramedical program that is proposed in the State and to recommend action to the Board.

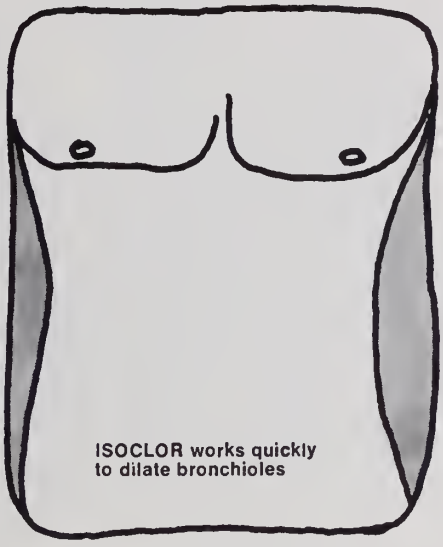
Other agenda items included a status report on Health Careers in Kentucky, Inc. and a discussion on the feasibility of the committee designing an exhibit for use at Health Career Programs in Kentucky.

Robert M. Runge, M.D., Covington, was recently elected as a Fellow in the American Academy of Orthopaedic Surgeons. Induction into the Academy took place January 19 during the 37th Annual Meeting of the Academy in Chicago.

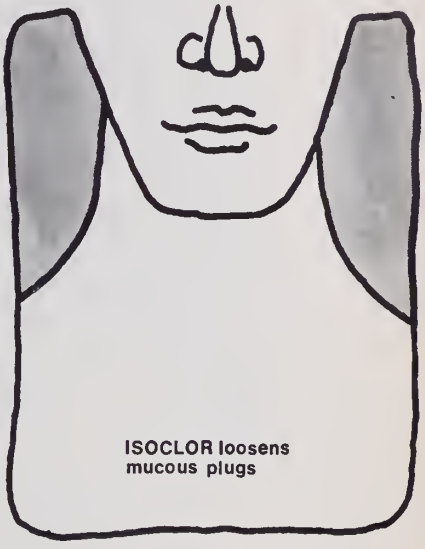
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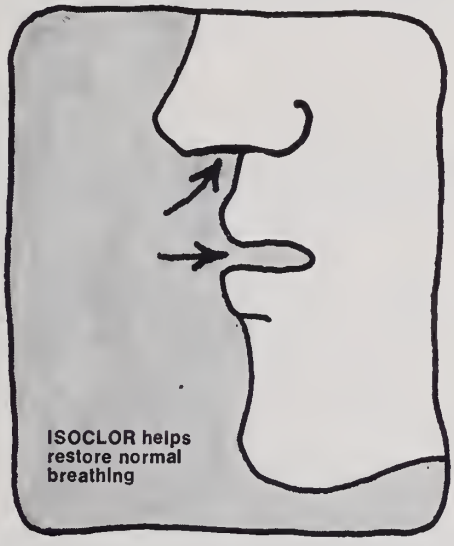
ISOCLOR works quickly to dilate bronchioles



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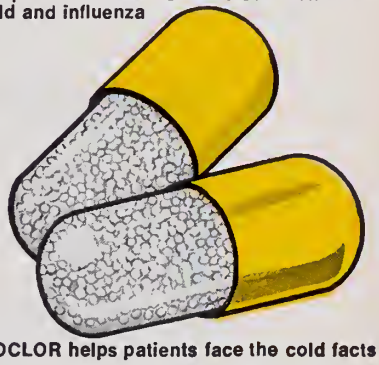


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40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
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15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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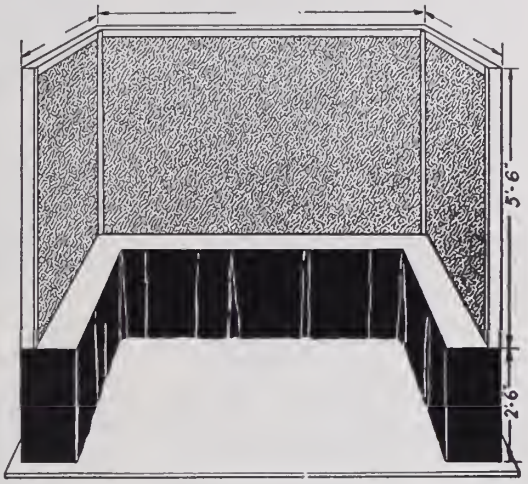
Kentucky Medical Association

3532 Ephraim McDowell Drive

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1970

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....
   Institution (if desired): .....
   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)
   Charts and Posters.... Photographs.... Drawings.... X-rays ....
   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
   Amount of total wall space needed? .....
   Back wall .....Side walls (All side walls are 4') .....
   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided to you in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....
Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

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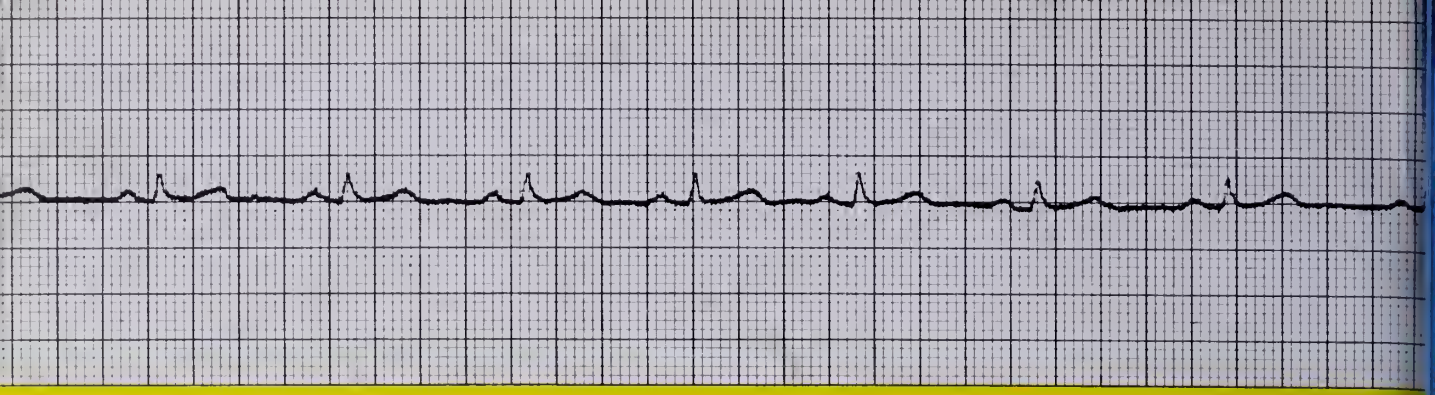
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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KMA 1970 Annual Meeting
September 22-24
Convention Center, Louisville

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Subscription $10 (Members $5)
Single copy $1
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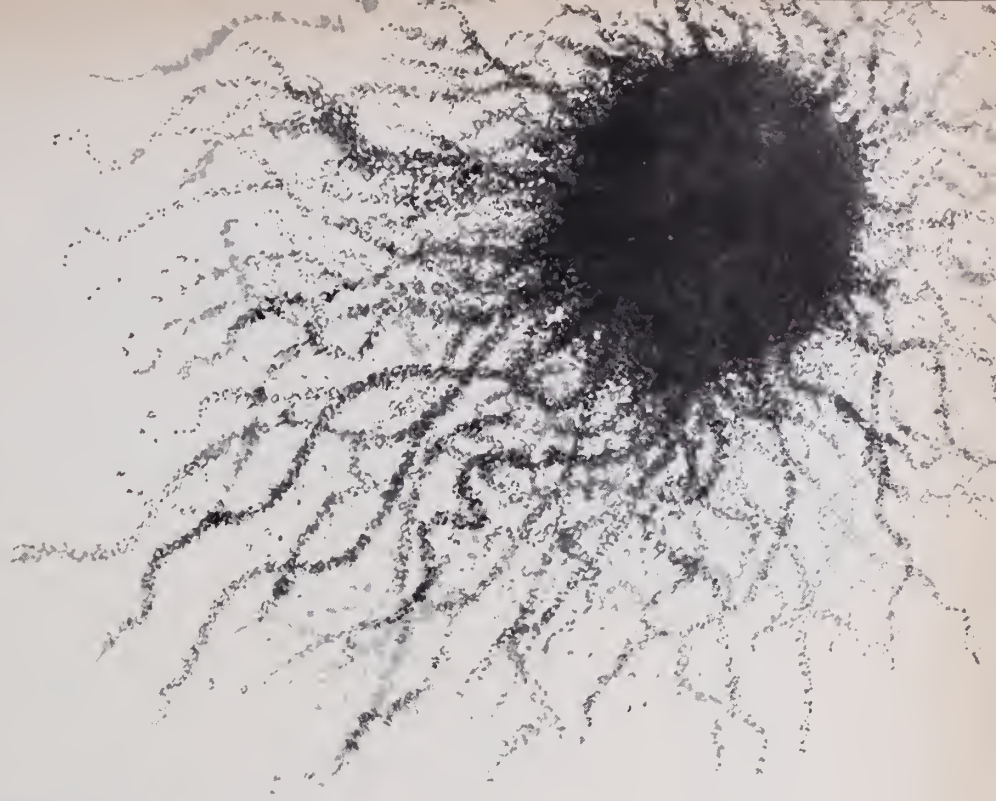
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Corticosteroid therapy week after week.

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For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MESSAGE FROM THE PRESIDENT



KMA Interim Meeting

Members attending the Interim Meeting enjoyed a stimulating and interesting session at Kentucky Dam Village on April 8th and 9th. One of the topics discussed, Peer Review, a top priority for us in medicine, may be our last chance to prevent mastery by those outside medicine. The physician is in the best position to determine fees and quality of medicine. No physician or group of physicians can afford to remain aloof. Peer Review, while affording physicians the opportunity for self-evaluation, does require time and effort. Medicine will not spend time more wisely than that spent in Peer Review. If physicians don't do it, Doctor Roger Egeberg recently questioned who else is there to evaluate physicians? The right of a professional person to be reviewed by his peers goes back in to English history for hundreds of years.

Doctors Robert Ewer and D. Robert Howard appropriately and effectively discussed the Physician's Assistant (Associate). As in any training program there must be an adequate curriculum. Even more fundamental is an adequate clinical facility for practical experience coordinated with the academic requirements. Doctor Howard stated that in North Carolina there are twice as many patients per physician as the national average. The associate is not for every physician. He does, however, add eyes and hands for those physicians with too many patients. I am impressed that many physicians for years have used personnel more efficiently to increase productivity. The Physician Assistant is a further bonus for use where there is an established need.

Mr. J. Ed McConnell, president of Blue Cross-Blue Shield, blended a serious message with many good 'ole Kentucky jokes. The attentive audience heard him say "A compulsory health plan will not solve today's health problems." He further stated that it would not lower the cost of care or increase the capability to deliver adequate health care to the poor. He felt that a compulsory plan may compound the problem. Mr. McConnell is optimistic about the voluntary system and I join with him in predicting an even greater involvement of the private sector. I also believe that we can receive usual and customary fees if we show that the service rendered is worth the buck received.

Walter L. Cawood

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 22-64. This 34-year-old, married, G 6, P 5, had an expected date of confinement by menstrual history of January 27, 1965. The patient was first seen on June 29, 1964 in a prenatal clinic for routine examination. History at that time was essentially negative except for an undocumented history of previous hypertension. On physical examination at this date, the blood pressure was found to be 176/90. She weighed 148 pounds. Routine physical examination showed the thyroid to be three to four times normal size; the rest of the physical examination was normal. The uterus was the size of a six to eight weeks pregnancy with a soft bluish cervix which represented early pregnancy. Because of the finding of an enlarged thyroid, the patient was referred to general medical clinic, and subsequently admitted to the medical service for work-up. A diagnosis of hyperthyroidism was made and the patient was discharged on July 24, 1964; on Propylthiouracil 300 mg. daily by mouth to be taken for four to eight weeks, after which the patient would be switched to thyroid. As far as can be determined, the patient took Propylthiouracil in the recommended doses until she ran out of medicine. She did not have the prescription refilled, and did not return to clinic.

The patient was next seen in the emergency room on the evening of November 19, 1964, complaining of shortness of breath and orthopnea. Because of this the patient was admitted to the obstetrical service. At this time she said that she had taken no medication for one week prior to admission. Since that time she had had episodes of smothering spells and expressed a dislike for warm weather. On physical examination, the blood pressure was 160/94, Pulse 126. The thyroid gland was diffusely enlarged to three to four times normal size. The chest was clear. The heart examination showed sinus tachycardia. The uterus was near term size with a fetal heartbeat counted at 160 in the left lower quadrant. The cervix was closed and uneffaced with the fetal head at station −3. The patient had 3+ pitting edema and a fine tremor in the extremities.

The initial impression at that time was intrauterine pregnancy, hyperthyroidism and possible cardiac failure. The PBI was 14 mcg. and the T-3 uptake was 30 per cent. Medical consultation was obtained and the patient was started on 100 mgm of Propylthiouracil every eight hours. She was discharged to prenatal clinic on December 4, at which time she had a blood pressure of 150/90, urine negative for albumin, and 1+ edema. The fundus was at a level compatible with pregnancy at term. The head was engaged with the fetal heartbeat of 120 in the left lower quadrant. No complaints were noted.

The patient was next seen on the night of admission, December 26, 1964, when she was admitted from the emergency room in critical condition, severe shortness of breath and cyanosis. The patient was first seen in the delivery room. She was in acute distress, the cervix was completely dilated with the fetal head distending the perineum. An intravenous drip was started to which aminophylline was added, and the patient was given 15 mg. of morphine sulphate intramuscularly. The anesthesiologists were called and came immediately to start positive pressure oxygen by means of an endotracheal tube. A non-sterile low forceps delivery was done delivering a living male infant weighing 8 lb. 3 oz. Immediately after the infant was delivered, maternal digitalization was started intravenously. The patient's EKG was monitored continuously. Shortly thereafter the patient had a cardiac arrest and for approximately the next 20 minutes, intermittent closed cardiac massage was done. During this time the patient would resume her own heartbeat only to stop in 10 to 15 seconds after cardiac massage had been stopped. During this time the patient was given neosynephrine intravenously to maintain a blood pressure of approximately 80. Sodium bicarbonate and calcium chloride were also given. Because of continuing asystole, Isuprel 0.2 mg. was given directly into the myocardium through the chest wall. Shortly thereafter, the patient was able to maintain her own hearbeat at approximately 150 per minute. Positive pressure oxygen continued

to be given. It was then decided to transfer the patient to the recovery room where she was placed in hypothermia. Respirations were maintained by means of a positive pressure ventilator. The patient remained unconscious but later was able to maintain spontaneous respirations and heartbeat. The systolic blood pressure was maintained in the range of 80 to 100 by means of an IV neosynephrine drip. However, at approximately 1:00 a.m. on December 27, 1964 the blood pressure dropped and did not respond to the vaso-pressor drip. At approximately 1:15 a.m. on December 27, 1964, cardiac arrest again occurred with dilatation of the pupils. The patient did not respond and was pronounced dead. The probable cause of death was listed as: (1) acute pulmonary edema, possibly secondary to (2) thyrotoxic heart disease. No autopsy was obtained.

Comment

The patient was completely negligent or not properly informed of the seriousness of her condition. It would appear that adequate and proper medical care would have controlled the hyperthyroidism. Several excellent reviews concerning this condition have recently been published[1,2].

The Committee considered that perhaps induction of labor might have been carried out when she was well controlled in early December.

References

1. Griffen, Ward O., Jr., Dilts, Preston V., Jr., and Roddick, John W., Jr.: Current Problems in Surgery, A series of Monthly Clinical Monographs, November 1969.
2. Werner, S. C.: Panel discussion on hyperthyroidism. I. Hyperthyroidism in the pregnant woman and the neonate., *J. Clin. Endocrinol.* 27:1637, 1967.

GENERAL PRACTITIONER

General Practitioner—for active general and industrial practice group in St. Louis County. The group includes one physician from Kentucky and one from Tennessee. Excellent remuneration with time for education. Cultural and educational facilities of St. Louis readily available. Send replies to Macon Medical Center, 7200 Manchester, St. Louis, Missouri 63143.

Brief Summary of Prescribing Information—9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®
hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

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The antihypertensive therapy that is easy to live with.*

When successive blood pressure readings confirm essential hypertension, consider Salutensin for:

Easy-to-live-with control. Gradual reduction of blood pressure leading to decisive, comfortable control is the common clinical response.

*Salutensin is usually well-tolerated (however, serious side effects can occur; see adjacent column for brief summary of prescribing information).

Easy-to-live with dosage. Two tablets a day usually achieves control. One to two tablets a day often maintains control without need for additional antihypertensive agents.

Easy-to-live with cost of therapy. The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.





ANSWERS TO YOUR QUESTIONS ABOUT BLUE SHIELD

Blue Shield Answers Your Questions About the Revised Physicians Service Report

Q. Why was it necessary for Blue Shield to revise the Physicians Service Report (Blue Shield Claim Form)?

A. The Physicians Service Report was revised to enable Blue Shield to process more claims routinely, with a reduced number of requests from our office for additional information; and to enable Blue Shield to accumulate data for the Usual and Customary Program.

Q. Why is it necessary to report the patient's age on the Physicians Service Report? (Item #4)

A. Most Blue Shield members have contracts where the coverage of dependents ceases upon their 19th birthday; in some instances this might be the 23rd or even the 25th birthday, depending on their specific contract and its conditions, and this information is important because it enables Blue Shield to determine the eligibility of the patient.

Q. Shouldn't the **subscriber's** place of employment rather than the **patient's** place of employment be reflected on the Physicians Service Report? (Item #18)

A. No, only the **patient's** *place of employment should be reflected in Item #18 of the Physicians Service Report. If the patient is of employment age but is unemployed, please state this. This information is especially valuable in determining Blue Shield liability where Coordination of Benefits has been placed in effect.*

Q. When should the revised Blue Shield Physicians Service Report be completed for patients age 65 or over? (Item #19)

A. Many Blue Shield subscribers, over age 65, are enrolled in a Carve Out type of coverage which supplements but does not duplicate Medicare, Part B, benefits. Subscribers having this type of coverage are identified by the Blue Shield Coverage Code 98-98 as outlined on Pages 8 and 12 of the Physicians Manual. Services for these and all Federal Employee Program subscribers over 65 should be filed on the regular Physicians Service Report with Item #19 completed. Blue Shield will then reimburse direct to the physician.

Q. Should the physician, who charges the same daily fee for in-hospital medical care break down his charge into first day, second day, and third and subsequent days on the Physicians Service Report? (Items #35, #36, #37)

A. Yes. This information is extremely valuable to Blue Shield in the administration of the Usual and Customary Program. If the physician charges the same amount for each day, the actual dollar amount should be entered in all three items. (#35, #36, #37).

Q. May physicians file for multiple services on one Physicians Service Report when the services are rendered to the same Blue Shield member?

A. Obstetrical care and related anesthesia, and fractures and related x-rays may be filed on one Physicians Service Report when rendered on the same date. Also, if there is a series of treatments such as x-ray therapy, radiation therapy, or laboratory services, they may be filed on one Service Report; however, **each service, its date, and the charge for each service should be listed separately.**

Q. What is the proper procedure for inquiring to Blue Shield about a particular claim or section of the Physicians Service Report?

A. In order for Blue Shield to promptly and correctly answer claims inquiries, each inquiry should give the patient's name, the subscriber's name, the certificate number, the type of service, the date of service, and the Physician Service Report item number in question.



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., ominophylline 195 mg.)

0915A 1/70



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Controindications: Known sensitivity ta sulfanamides.
Precautions/Adverse Reactions: The usual precautians far tapical and systemic sulfanamides shauld be observed because af the passibility af absarptian. Burning, increased lacal discamfart, skin rash, urticaria ar ather manifestatians af sulfanamide taxicity are reasans ta discantinue treatment.
Dosage: One applicatarful ar ane suppasitary intravaginally ance ar twice daily.
Supplied: Cream—Faur-aunce tube with ar withaut applicatar. Suppasitaries—Bax af 12 with applicatar.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Parter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystawsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: Sauth. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Ta-day's Drugs, New Yark, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnastic and Therapeutic Appraach, Scientific Exhibit, presented at the 115th Annual A.M.A. Canventian, Chicaga, Illinais, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilsan, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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PUBLIC HEALTH PAGE

Serologic Tests For Rubella: Availability and Interpretation†

Russell E. Teague, M.D., M.P.H.

Commissioner of Health

Commonwealth of Kentucky

SEROLOGIC tests for rubella provide a practical method for determining: (1) the immune status of individuals in a given population; (2) the immune status of pregnant women who have been exposed to rubella; and (3) the etiology of cases of exanthematous disease or suspected cases of congenital rubella syndrome.[1]

Among available serologic methods, the rubella hemagglutination-inhibition (HI) antibody test has the greatest general applicability, since it is the most rapid, sensitive and economical procedure.[2,3] However, it is well to remember that the HI test is a complex procedure which must be performed by well trained, experienced technicians. In addition, the results must be interpreted by individuals who possess a thorough knowledge of the immune response to rubella virus infection.

Epidemiology and Immunology

A brief review of certain aspects of the epidemiology and immunology of rubella are basic to the proper utilization and interpretation of rubella HI serology reports. The usual incubation period for the disease is 14 to 18 days with a range of 12 to 21 days. Rubella virus can be excreted from the pharynx for up to seven days prior to onset of the rash. Measurable increases in HI antibody titers begin within 24-48 hours after onset of rash, peak within 6-12 days, and persist for years. Inapparent infections are common; in as many as 20-50 per cent of the cases no evident rash is exhibited.

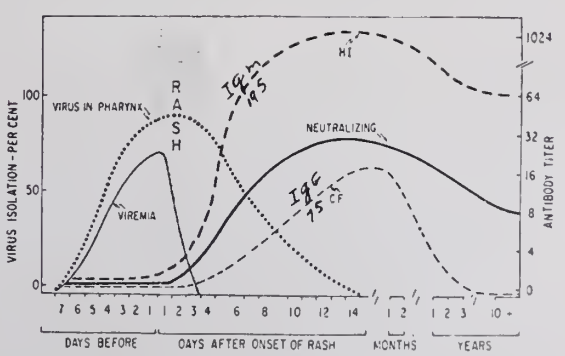
Several of these points are illustrated in the accompanying figure.

Interpretation and Significance of Serologic Results

It is obvious that there is no way to make a definitive diagnosis of rubella in the patient first seen more than a few days after onset of rash. However, in instances where a pregnant woman has been exposed to a possible case of rubella, she should have a sample of serum collected within seven days of the exposure. If at that time her HI titer is 1:10 or greater, this indicates immunity due to prior experience with the antigen, and there should be no further cause for concern. If it is less than 1:10, then she should be considered susceptible to the disease and a convalescent serum collected and titered three to four weeks later in order to ascertain whether or not effective exposure took place. It should be noted that the second specimen is necessary regardless of the presence or absence of clinical symptoms.

Serologic diagnosis of rubella syndrome is based on the fact that maternally transferred rubella antibody disappears from the infant's circulation by six months of age. Therefore, a persistent rubella HI titer at six months of age is presumptive evidence of in-utero rubella infection.

Another practical application of rubella HI serology is selective screening of adolescent girls and women of childbearing age in order to determine susceptibility to the disease. If the HI titer is less than 1:10, and the individual is not pregnant at the time and will not become pregnant for two to three months, she may be considered for rubella immunization. Recent serologic surveys indicate that approximately 15 per cent of Kentucky females between 15-45 years of age have no measurable circulating antibody against rubella virus.



†*This article was prepared by The Office of Communicable Disease, Division of Epidemiology, Kentucky State Health Department, 275 East Main Street, Frankfort, Kentucky 40601*

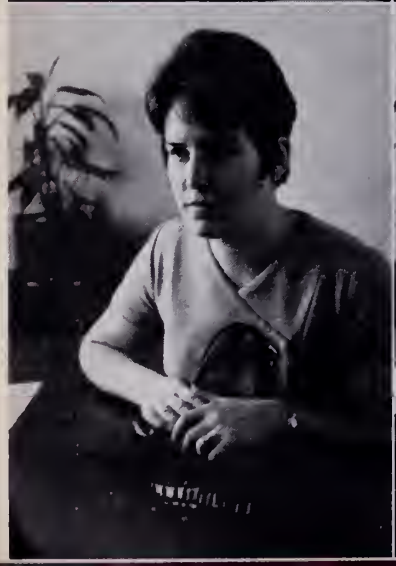


Not just the tough cases...

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Symptoms subside in 48 to 72 hours!
Itching, burning, discharge, and malodor disappear rapidly... patient's embarrassment, too.

Avoids the disappointment of "the cure that didn't take."
CANDEPTIN is "cidal" as well as "static," it is 100 times more potent *in vitro* than nystatin,[2] and it has achieved culture-confirmed cure rates of 90% and more[3] (even in notoriously difficult-to-treat pregnant patients)![1,3,4]

And two weeks does it.
Usually, CANDEPTIN cures in a single 14-day course of therapy.[3]

the fortnight fungicide

Candeptin®
candicidin
Vaginal Tablets/Ointment

Formula: CANDEPTIN Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% candicidin activity in U.S.P. petrolatum. 3 mg. of candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain candicidin powder equivalent to 3 mg. (0.3%) candicidin activity dispersed in starch, lactose and magnesium stearate.

Indications: Vaginal moniliasis due to *Candida albicans* and other Candida species.

Contraindications: Patient sensitivity to any of the components. During pregnancy manual tablet insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment or Vaginal Tablets have been extremely rare. To avoid reinfection, it is recommended that the patient refrain from sexual intercourse during treatment or the husband wear a condom.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet is inserted high in the vagina, twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Dosage forms: CANDEPTIN Vaginal Ointment is supplied in 75 gm. tubes with applicator (14-day regimen requires 2 tubes). CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil, with inserter—enough for a full course of treatment. Store under refrigeration.

Federal law prohibits dispensing without prescription. CANDEPTIN is a registered trade-mark of Julius Schmid, Inc.

References: 1. Olsen, J. R.: Journal-Lancet 85:287 (July) 1965. 2. Lechevalier, H.: Antibiotics Annual 1959-1960, New York, Antibiotica, Inc., 1960, pp. 614-618. 3. Giorlando, S. W., Torres, J. F., and Muscillo, G.: Am. J. Obst. & Gynec. 90:370 (Oct. 1) 1964. 4. Friedel, H. J.: Maryland M. J. 15 36 (Feb.) 1966.

Julius Schmid Pharmaceuticals
423 West 55th Street
New York, N.Y. 10019

(Continued from page 279)

Availability of Laboratory Tests for Rubella

The Virology Section, Division of Laboratory Services, Kentucky State Department of Health, is now able to accept an increased number of selected specimens for rubella HI serology. Several private laboratories also offer comparably competent service.

The test requires approximately three to five ml. of serum or eight to ten ml. of whole blood collected aseptically. No preservatives should be added, nor should the specimen be frozen.

Each specimen should be accompanied by the following minimal information:

1. Physician's name and address
2. Date of rash or date of exposure
3. Purpose of test (immune status of exposed pregnant woman or possible vaccine recipient, confirmation of infection, etc.)
4. Patient's name, address, age and sex
5. Date of specimen collected

Suitable containers and submission forms for this purpose are available at all local health departments in the state.

Specimens should be mailed or delivered to:

Virology Section
Division of Laboratory Services
Ky. State Department of Health
275 East Main
Frankfort, Kentucky 40601

References

1. Recommendation of the Public Health Service Advisory Committee on Immunization Practices. National Communicable Disease Center Morbidity and Mortality Weekly Report, Vol. 18, No. 15, April 12, 1969.

2. Cooper, Louis Z., Rubella: A Preventable Cause of Birth Defects. Original Article Series of the National Foundation, Vol. IV, No. 7, pp 23-35, December, 1968.

3. Cooper, Louis Z. and Krugman, Saul, The Rubella Problem, *Disease-A-Month*, February, 1969.

Private Practice Opportunity in Lexington, Kentucky

Drawing from 700,000 population. Five modern hospitals with open staff privileges including University of Kentucky Hospital. We need 2 Family Physicians, 1 Radiologist, 2 Internists, and 1 General Surgeon to furnish the required services. Write Box 7264, Lexington, Kentucky 40502.

A Link in the Chain

auxiliary

A Day of Honor

March 30 is the date that doctors are honored in the Southern Medical Association. This includes 16 southern states, the Canal Zone, District of Columbia and Puerto Rico. This date was not picked at random, but has true medical history.

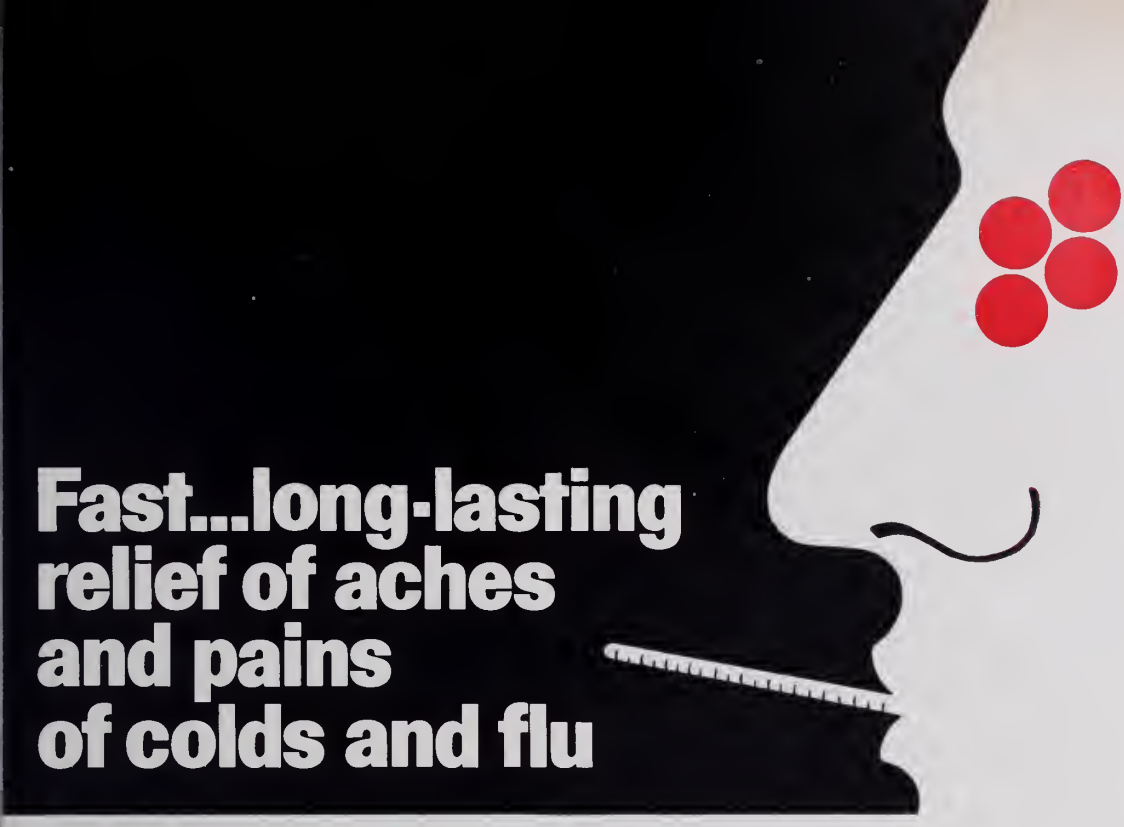
March 30, 1842, Crawford W. Long, M.D., a Georgia physician, first used ether as an anesthetic agent in a surgical operation, thereby, giving patients blessed relief from pain and suffering during surgery. The first observation of Doctors' Day was March 30, 1933, and the red carnation was adopted as the official flower in 1949.

This year, as in many past years, our doctors in Kentucky were honored on March 30, by the Auxiliary. Roses and holly trees were purchased for hospital gardens. Flowers were placed in hospital waiting rooms, a breakfast, as well as donuts and coffee, was served in a doctors' lounge. Several Auxiliaries gave histories, dinners, a dance, AMA-ERF contributions, books to be placed in libraries, a scholarship, a window display in a local merchant's store window and appropriate news and radio coverage. One of the Auxiliaries even persuaded one of their doctors to have a physicial examination.

At the Interim Meeting in Gilbertsville April 8, the Woman's Auxiliary to the Kentucky Medical Association presented a proclamation from Governor Louie B. Nunn, proclaiming March 30 as Doctors' Day throughout the state. At that time we presented officers and guests with a red carnation.

Doctors, we are proud of you and your service and we are proud to be your Auxiliary and be at your service.

Mrs. Hoyt D. Gardner, President
Woman's Auxiliary to KMA



Fast...long-lasting relief of aches and pains of colds and flu

with the unique timed-release aspirin

Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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MEASURIN®
TIMED-RELEASE ASPIRIN
ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF
Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

in active stages of moderate to severe rheumatoid arthritis,

What more can you

after you've tried



rheumatoid spondylitis, and osteoarthritis of the hip

do for these patients?

salicylates and rest



INDOCIN®

(INDOMETHACIN | MSD)

helps relieve pain, fever, swelling, and tenderness

Please see new prescribing information on following page.



REVISED PRESCRIBING INFORMATION

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

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Many medical organizations are setting date for their summer and fall meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Ephraim McDowell Drive, Louisville, Ky. 40205.

IN KENTUCKY

MAY

12-14 Spring Meeting, Kentucky Chapter, American Academy of Pediatrics, Lookout House, Covington

13 PANMED television series, "Drug Information," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

15-17 Annual Convention, Kentucky State Association of Medical Assistants, Stouffers Inn, Louisville

15-16 Annual Meeting, Kentucky Obstetrical and Gynecological Society, Brown Hotel, Louisville

15-16 Annual Meeting, Kentucky Surgical Society, Kentucky Dam Village State Park, Gilbertsville

18 PANMED television series, "Drug Information," in Louisville WKPC-TV 10 p.m.

20 PANMED television series, "Fractures in Children," KETV-TV 9:30 p.m. EST (8:30 p.m. CST)

23 Spring meeting, Kentucky Society of Anesthesiologists, Lexington

25 PANMED television series, "Fractures in Children," in Louisville WKPC-TV 10 p.m.

SEPTEMBER

16-19 Emergency Care and Transportation of Sick and Injured Persons advanced course, University of Kentucky, Lexington

22-24 Annual Meeting, Kentucky Medical Association, Convention Center, Louisville

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Kentucky Medical Association

Issued Monthly Under The Direction Of The Board Of Trustees

VOLUME 68 May 1970 No. 5

1970 Student Research Day
University of Kentucky School of Medicine

The Journal is pleased to publish abstracts of the 10 papers chosen for presentation on Student Research Day at the University of Kentucky Medical Center. Judging of the papers presented was based on scientific merit and quality of the presentations.

The first Student Research Day, held on January 17, 1970, attracted 22 papers in all. A panel of judges composed of clinical and basic science faculty chose the following for awards: J. David Richardson, first-place; B. A. Bivins, second-place; and Denis Becker, third-place.

The Effect of the Ileocecal Valve on Intestinal Absorption

J. David Richardson and E. Scott Medley (1st Place)

The ileocecal valve (ICV) enhances intestinal absorption by (1) delaying passage of nutrients through the small bowel and (2) by preventing the retrograde passage of bacteria from the colon into the small intestine. Previous work has emphasized the importance of the decreased transit time following ileocecal valve resection, whereas this study explores the effect on absorption produced by retrograde bacterial infection in the small bowel.

Fourteen mongrel dogs underwent control studies including determinations of transit time, D-xylose absorption, fecal fat content and body weight. Intestinal resections were then performed removing 57 inches of terminal small bowel in all animals; seven dogs had the ileocecal valve preserved while it was resected in the remainder. Prior to resection bacterial samples were taken proximal to the ileocecal valve, at the mid-ileum and the ligament of Trietz. Ten days later the control studies were repeated and a laporatomy performed to collect bacterial samples as before. The fecal fat increased in animals with an intact ICV by only 97 per cent while it increased by 212 per cent in the animals with the valve resected. D-xylose absorption changed little in the group with the ICV intact but increased 25 per cent in the other groups. Weight loss occurred in both groups but was more pronounced in those animals without an ICV. The transit time was not decreased from control levels in either group. Control bacterial counts from the ligament of Trietz and mid-ileum were essentially sterile while moderate growth occurred at the ileocecal valve (200,000 colonies/ml). There was no significant change in the bacterial flora in animals with an intact ICV after 10 days. Those dogs without ICV had grossly feculent material above the anastomoses with a mean colony count of greater than 17 million colonies/ml. These animals also had a marked bacterial contamination in the middle of the small bowel, however, the infection did not extend to the ligament of Trietz.

We conclude that retrograde contamination of the small intestine is more important than a decrease in transit time in the malabsorption produced by resection of the ileocecal valve.

Post-Traumatic Respiratory Insufficiency (PTRI)

B. A. Bivins and W. C. Madauss (2nd Place)

The post-traumatic patient is commonly the victim of respiratory insufficiency within 72 hours following injury. The overall category of PTRI encompasses numerous poorly defined syndromes including "Wet Lung Syndrome, Fat Embolism Syndrome", etc.

Previous investigators have indicated consumption coagulopathy and/or alterations in flotation characteristics of fat in the blood to be involved in some cases of PTRI. Collins, *et. al.,* have shown "inapparent hypoxemia" to be a common early sequel to trauma and they suggest that this is due to fat embolism.

In our study, trauma was separated into components and adult mongrel dogs were subjected to each component (hemorrhage, blunt limb trauma) with and without open transverse fractures of both femurs. Arterial blood gases and pH, activated coagulation time (ACT), platelet count, and serum lipase were monitored.

Control dogs subjected to incisions only showed no significant change. Open fractures only caused an early fall in ACT and a 50 per cent fall in platelet count in the first hour post trauma. Hypoxemia did not supervene for 24 hours, at which time it appeared and persisted for about one week. Serum lipase levels rose on the third post-traumatic day.

Early hypoxemia (appearing within one hour) did not occur unless the animal was subjected to hemorrhage (40 cc/kg) without replacement or blunt limb trauma prior to fracture. In the absence of fracture, there was no early hypoxemia with hemorrhage or blunt trauma although both ACT and platelet count fell.

Intravascular fat emboli were visible on microscopic exam of pulmonary small vessels in all animals with femur fractures. Dogs used for blunt trauma alone, hemorrhage alone, and control dogs showed no fat on histologic exam.

Marrow Cell Chromosome Aberrations Following I. V. DMBA; Dose-Response

Denis Becker (3rd Place)

Polyaromatic hydrocarbons are among the components found in tobacco smoke, some of which (eg. benzo(a)pyrene) are quite carcinogenic. 7,12-Dimethylbenzo (a)-anthracene (DMBA), a polyaromatic hydrocarbon not found in tobacco smoke, has been shown to cause leukemia in rats after intravenous injection and the leukemia often is associated with redundancy of the Number 2 chromosome. In this study, a dose-response curve of karyotypic changes in marrow cells following intravenous administration of DMBA was obtained. Twenty-four hours after injection of 10, 20, 30 and 40 mg/kg doses of DMBA to male Long-Evans rats, chromosome preparations of the marrow from the tibias and femurs were made using hypotonic technique. The slides were then Giemsa stained and examined by oil-immersion microscopy. Two control groups, both maintained at constant metabolic and environmental conditions, were used, one group being left without injection while the second group was injected with a "blank" emulsion. The incidence of cells with chromosome gaps or breaks in the control populations varied from 3 to 12 per cent; the per cent of chromosome abnormalities in the rats given the 10, 20, 30 and 40 mg/kg doses were 18.9, 29.5, 40.5 and 46.3 per cent, respectively. Also, paralleling the above-mentioned redundancy of the Number 2 chromosome associated with DMBA-induced leukemia, DMBA was found to have preferential effects on Number 1, 2 and 3 chromosomes, more abnormalities being observed in these chromosomes than would be expected by chance alone (noting the incidence of abnormalities in relation to these chromosomes' contribution to the total of chromosome lengths per cell).

Thus, DMBA has been shown to damage the chromosomes early, hours after injection,

leukemia occuring weeks later. These findings seem consistent with a "chromosomal theory of oncogenesis". That is, an agent which can alter the control mechanisms of a cell, (i.e. altered DNA which is reflected in abnormal chromosome morphology) can subsequently change the functional capacities of a cell. In this light, cancer is viewed as a condition of inadequate control of cell function. It follows from this DMBA model system, that if it can be established, 6-24 hours after I.V. administration of an unknown compound, that the incidence of resultant chromosome breaks in rat marrow cells accurately reflects the carcinogenic potency of that compound, then it is possible to develop a rapid and convenient bio-assay technique which will be available for the assessment of the carcinogenicity of, for instance, components of tobacco smoke.

The Differences in the Sensitivity of the Adenohypophysis to the Median Eminence Extract (MEE) In Male and Female Rats

Nada Chang and M. B. Nikitovitch Winer

The existence of the differences in the hypothalamic thresholds for the release of LH-releasing factor (LRF) in male and female rats is well established. The aim of this investigation was to determine whether similar differences exist at the level of the adenohypophysis in terms of its responsiveness to MEE (containing LRF), as judged by the release of ovulatory amounts of LH. Females in proestrus and during the third day of diestrus, and castrated male rats (implanted with an ovary for 30 days) received 0.027 to 7.20mg of MEE (4.2mg=1 MEE fragment) through a cannula stereotaxicly implanted into adenohypophysis. The lowest dose which induced the release of a very small number of ova in one third of the cases was 0.027mg for proestrus, and 1.8mg for diestrous females. The latter dose induced maximal ovulation in all proestrus animals while a four times higher dose elicited still only moderate ovulation in diestrous animals. The threshold dose for luteinization of ovarian grafts in males (examined two days after the infusion) was 0.113mg, while 1.8mg induced full luteinization.

The results indicate that the sensitivity of the adenohypophysis to LRF is higher on the day of proestrus than during the third day of diestrus. Males show an intermediate sensitivity. The increase in the pituitary thresholds to LRF during diestrus might serve to prevent the release of ovulatory amounts of LH at a time when the ovarian follicles have not reached full development. Relatively high thresholds in the male might be due to the inherent non-cycling pattern of the secretion of the hypothalamic LRF.

Is Mutarotase the Isolated Form of the Elusive Sugar Carrier?

Charles H. Stringham

The inhibitory potency of various phlorizin and phloretin analogs on hamster intestinal mutarotase was determined, and the results were compared with known action of these compounds on various sugar transport systems. When considering the effect of a series of glycosides on mutarotase and the sugar carrier of intestinal and kidney brush border epithelia, some interesting similarities in inhibitory activity were noted, but the differences were far more striking. On the other hand, mutarotase and the human erythrocyte sugar carrier were similarly inhibited by a series of phenolic aglycones. These findings are interpreted from three viewpoints: first, the brush border sugar carrier differs from both mutarotase and the RBC carrier; second, mutarotase and the RBC carrier are identical; and third, the protein in all three systems possesses the same active center, and the difference in their observed responses to the inhibitors is due to dissimilarities in their normal membrane environment.

The Influence of Child Mortality on Fertility Rates In An Underprivileged Society

Michael Howard Hall and Franz Theard

The purpose of the study was to determine the effects of child mortality on fertility in an effort to clarify the possible effects that better public health measures might have on the population explosion in developing nations such as Haiti. A total of 605 women between the ages of 15 and 55 were interviewed in Les Cayes, Haiti. Of the 389 women who were married five years or longer, 132 (33.9 per cent) experienced no child death, 195 (50.1 per cent) experienced a death at any age less than five years and in one of the first three birth orders, and 62 (16 per cent) experienced a death in the fourth or later birth order or at an age of five years or older. Of the 257 women with a child death experience, then, 75.9 per cent had the first death occur in the first three birth orders less than five years of age (hereafter the definition of child death experience.

A positive correlation between child death experience and fertility was found to be significant regardless of educational status of the mother. Further, age specific fertility rates for 1968 were found to be roughly twice as high for women with child death experience as for those with no child death. The same positive correlation between child mortality and fertility and also the same concentration of child deaths in the first three birth orders were found in women (ages 45-55) who had completed their reproductive periods. The concentration of deaths at the beginning of these mothers' reproductive periods strongly suggests that the child death experience is motivating the affected mothers to reproduce at a greater rate than the unaffected mothers regardless of socioeconomic status. How mothers manage this in a society where modern contraception is virtually unavailable is a most provocative question. The tremendous implications of this finding for future approaches to the population problem are discussed.

After Image Suppression of Vestibular Induced Nystagmus

Charles W. Patterson and H. Martin Blacker

It has long been known that fixation suppresses vestibulo-ocular responsivity. That is, when the vestibular apparatus is stimulated, either by rotation or by caloric testing, the nystagmus induced tends to be suppressed if the patient fixates on an object.

Fortuitously, it was found that the stimulus of fixation provided by an after image would suppress vestibularly induced nystagmus. When a subject's eyes are closed and the head rotated slowly from side to side nystagmus is induced in all normal subjects. This nystagmus may be detected either by the lightly palpating finger or by electro-oculography. With the patient's eyes open, fixating upon an object the nystagmus induced by head rotation from side to side is totally suppressed. When an after image is put on the fundus by means of a special strobe target and the patient's eyes closed he can retain fixation enough to totally suppress nystagmus induced by head rotation.

Twenty normal subjects were selected and the after image test performed. In every subject nystagmus was totally suppressed when the after image was retained. When nystagmus appeared the subject invariably reported that he had "lost" the after image. By concentration the after image could be refurbished as a point of fixation and again nystagmus suppressed.

It is known that directional preponderance of nystagmus may indicate a lesion of the cerebral hemisphere. This minimal degree of stimulation of fixation by the after image and the minimal amount of stimulation to produce nystagmus by slow head rotation promises to provide a sensitive indicator of directional preponderance in hemisphere lesions. The examination is relatively easy to perform and is totally without risk.

Effects of Breathing 100 Per Cent Oxygen on Susceptibility to Pulmonary Edema

Roger Morehouse, David Richardson and Benjamin Rush

Twenty-seven dogs were divided into five groups and the effects of breathing 100 per cent oxygen or room air with and without a positive pressure respirator were determined while the central venous pressure was maintained at 15 mm. Hg. by intravenous infusion of modified Hartmann's solution. Dogs received fluid to 1000 cc/kg or to pulmonary edema developed.

The following groups were studied: 1) room air through spirometer and respirator, 2) 100 per cent oxygen through spirometer and respirator, 3) room air breathed spontaneously from spirometer, and 5) 100 per cent oxygen for 24 hours before intravenous infusion.

Results

No dogs of group 1 developed pulmonary edema before 1000 cc/kg was infused. Four of six dogs in group 2 and all of groups 3, 4 and 5 developed pulmonary edema before the maximum infusion was reached. Dogs breathing 100 per cent oxygen developed edema in a shorter period than dogs breathing room air, 95 minutes vs. 180 minutes. Dogs exposed to 100 per cent oxygen before infusion developed edema after 57 minutes. Dogs breathing room air without a respirator (group 3) required a larger fluid load to produce edema (580 cc/kg) than all dogs breathing oxygen either with or without a respirator (group 2—390 cc/kg group 4—345 cc/kg and group 5—280 cc/kg).

Conclusions

(1) Acute exposure to 100 per cent oxygen will promote the early onset of pulmonary edema;

(2) Chronic exposure to 100 per cent oxygen will enhance this effect even further, and

(3) The use of a piston respirator will afford some protection against developing pulmonary edema.

S-100 Protein Determination in Normal Brain and Brain Tumors

Stephen Spires, Horace Norrell and Donald Slagel

S-100 protein, so named because of its solubility in 100 per cent saturated ammonium sulfate, is a high acidic protein unique to the vertebrate nervous system. Its discovery by Moore and McGregor in 1965, prompted efforts to determine its cellular localization and function. Its uniqueness makes it a useful tool for studying normal and neoplastic glial tissue. To provide a uniform and non-exhaustible source of both normal and tumor tissue, we have injected rats with methylnitrosourea, a carcinogenic compound having a high specificity for the nervous system.

Method

The qualitative and quantitative determination of S-100 protein within cells or tissues is dependent upon immunodiffusion techniques, requiring a source of S-100 antibody. S-100 protein was extracted from sheep brains by preparative acrylamide gel electrophoresis with the pure protein being eluted from the gel. This protein complexed with methylated bovine serum was injected into rabbits for antibody production.

Results

S-100 protein has been demonstrated in 32 human glial tumors, while in seven intracranial tumors of non-glial origin the protein has not been present. We have also demonstrated another protein unique to the nervous system. Thus far only two transplantable intracranial tumors have been produced in rats and both were sarcomas. One does not contain S-100 and the latest has not been tested. It is our ultimate objective to isolate a transplantable glial tumor in rats so that we may more completely study the *in vivo* and *in vitro* production of S-100 protein in malignant brain tumors.

Treatment of Tetanus Using Intrathecal Tetanus Human Immune Globulin

James H. Kopp

The case fatality rate of tetanus has remained almost constant despite a declining incidence.[1] Curarization and maintenance on artificial breathing machines has achieved some success, but these techniques are available only in sophisticated medical centers and are costly.

Free toxin has been demonstrated in the spinal fluid of tetanus patients and circulating antibodies permeate the blood-brain barrier poorly if at all. In studies here on dogs, CSF levels of antitoxin were at levels 1/238 to 1/2000 that of the blood.[2] Two tetanus patients were studied four days after receiving tetanus human immune globulin intramuscularly; no antitoxin was detected in the CSF at a level of 0.008 per ml.; blood levels in both cases were between 1.024 and 2.048 U. per ml.[3] These facts suggest neutralization of this toxin by direct intrathecal injection of antibody.

Recent work by Ibrahim Ildirim, M.D., at this University has shown efficacy of using intrathecal human immune globulin in treating experimental disease induced in dogs.[4]

Our hypothesis is then that intrathecal antitoxin is a rational part of tetanus therapy, and a protocol for treatment was developed. The object of this study is to establish the efficacy and safety of this protocol in treating human tetanus. A pilot study was planned and carried out in Jeremie, Haiti, an area where incidence and mortality of tetanus is high. For several reasons proper controls in this study were impossible and these reasons are explained in the paper. However, despite lack of controls, the results of this pilot study are noteworthy, and deserve consideration.

Following are the summarized results of this study: Ten patients were treated; seven were newborns; one was a six-year-old boy, and two were adult women in their early forties. Four of seven newborns were cured giving a mortality rate of 43 per cent as compared to a mortality rate of 77 per cent for neonatal tetanus in the United States.[5] The six-year-old boy, who had severe tetanus, was cured in eight days. One of the two adults, both of whom had moderate tetanus, was cured in five days. The second lady died on the second day of therapy from gangrene.

References

1. LaForce, F. M., et. al., "Tetanus in the United States (1965-1966)," *New England Journal of Medicine*, Vol. 280, pp. 569-574, 1969
2. Ildirim, I., Furcolow, M. L., and Smith, C. D., "Brain Barrier for Clostridium Tetani Toxin and Antitoxin in Dogs," *Bact. Proc.*, M90, p. 81, 1969
3. Ildirim, I., Meira, A. R., and Furcolow, M.D., "Tetanus," *New England Journal of Medicine*, 280, p. 1243, 1969
4. Ildirim, I., unpublished, Department of Community Medicine, University of Kentucky
5. LaForce, F. M., op cit. *New England Journal of Medicine*, 280, 1969

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Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

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Maintenance of Anabolism by Total Parenteral Nutrition in Patients*

Paul M. Walstad, M.D., William E. Bowers, Jr., M.D.
and Edwin J. T. Tolon, M.D.

With a new method of total parenteral therapy, it is now possible to maintain a patient in excellent nutritional condition. Prior infusion problems of vein thrombosis, over-hydration, and inadequate caloric intake have become less formidable.

Nutritional care of the surgical patient has been greatly enhanced through the concerted efforts of Dudrick and his associates at the University of Pennsylvania. They have demonstrated that tissue maintenance, synthesis and growth can be achieved by uninterrupted, 24-hour, daily intravenous administration of the basic nutrients over a prolonged period in those patients having feeding problems[1-7]. In recent months this method has been successfully used by us in 13 patients. Length of infusion ranged from four to 21 days with an average of 10 days. No complications resulted from the placement of the catheter in the superior vena cava, such as caval thrombosis and pulmonary emboli[8]. A representative case is presented.

Report of a Case

In August, 1969, at the Harlan Appalachian Regional Hospital, a 34-year-old white male underwent total gastrectomy, followed by a Roux-en-Y procedure for gastric malignancy. Ten days following operation he was placed on an oral liquid diet. The next day, however, ingested orange juice was noted appearing at the drainage tube site. A leak was suspected at the anastomotic site, and this suspicion was confirmed by esophagogram. Oral feedings were then stopped and intravenous feedings were restarted.

Four days later total parenteral feedings were begun through an indwelling catheter placed in the superior vena cava. The feedings were continued for 21 days, infusing hypertonic nutrient solutions having a daily caloric value of 2500 to 5000. Each day there was a re-evaluation of the type and amount of fluids to be given, based on knowledge of the patient's weight, urinary output, urinary sugar concentrations and serum electrolytes. During this period of total parenteral feeding the patient gained 9.2 kg (20.5 lb) in weight, starting at 36.3 kg (80 lb) and ending at 45.5 kg (100 lb). On hospital entry his weight had been 61.3 kg (135 lb).

As demonstrated by an esophagogram the small fistula at the anastomotic site was no longer evident. The abdominal wound was well healed. Parenteral feedings were then discontinued. A week later the patient was discharged for follow-up in the out-patient clinic. Three months after hospital discharge the patient had gained an additional 5.4 kg (12 lb).

Discussion

A patient's health can not only be maintained but improved during an enforced period of long-term, high caloric intravenous therapy. The process of anabolism is continued, as demonstrated by a positive nitrogen balance, better healing of tissues, weight gain and renewed vigor and improved mental outlook[4]. The problem of malnutrition, which contributes to such a significant morbidity and mortality in gastrointestinal fistulas[9], upper alimentary obstructions, severe burns and other clinical conditions involving disturbed oral intake, has been made less complex by the availability of this parenteral method of therapy.

The continuous, uninterrupted infusion of the amino acid-hypertonic glucose solution, in contrast to part-time infusion, insures that

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the amino acids will be less likely to undergo conversion to glucose, and the glucose to fatty acids. A two-fold purpose is served by the simultaneous infusion of the protein and glucose. The glucose, by meeting caloric needs, spares the protein; and the insulin, stimulated to secrete by the presence of glucose, assists in further protein synthesis and movement of amino acids into the cells[10].

Daily guides, as to the composition of the intravenous solutions to be administered, are knowledge of the patient's weight, urinary output, urinary sugar concentrations and serum electrolytes. The basic nutrient solution contains about 140 grams per day of protein hydrolysates, easily available from most hospital supply rooms. To this solution is added 50 per cent glucose solution in sufficient quantity so that one ml has a caloric value of one. Daily volume requirements will vary from 2500 ml to 4500 ml. As caloric requirements are gradually increased to meet the patient's needs there will usually be a temporary increase in urine sugar. The continued presence of sugar in the urine may be lessened by increasing the daily potassium requirements by as much as 200 to 250 mEq daily. These large amounts of potassium may be required as potassium has been known to accompany the movement of glucose into the cell[4].

During the insertion of the infusion catheter and until its removal it is imperative that sterile operating room technic be employed[5]. An eight-inch plastic catheter is inserted percutaneously through a No. 14 gauge needle into the right or left subclavian vein and directed into the superior vena cava. By placement of the catheter into such a wide vein thrombosis is decreased and large amounts of hypertonic fluid can be rapidly diluted because of the ample blood volume. The rate of administration of the fluids requires close supervision, as too rapid infusion can result in osmotic diuresis, dehydration and convulsions. Furthermore, protein hydrolysates will also be excreted into the urine with no proper utilization by the liver. Safeguards and details of the technic of administration have been described elsewhere[5, 11, 12]. The technic of parenteral feedings by an arteriovenous shunt, with which we have no experience, has been described by Conolly and Murphy[8].

Summary

Patients, who for a variety of reasons, require prolonged intravenous infusions can be maintained in a high state of nutrition by the method described. Wound healing, weight gain, improved vigor and mental outlook have been manifested. The technic of infusion and the basic ingredients in the infusion have been discussed. This method has been successfully carried out in 13 of our patients.

References

1. Dudrick, S. J.; Rhoads, J. E. and Vars, H. M.: Growth of Puppies Receiving All Nutritional Requirements by Vein, *Fortschritte Parenteral Ernahrung* 2:16-18, 1967.

2. Dudrick, S. J.; Wilmore, D. W.; and Vars, H. M.: Long-Term Total Parenteral Nutrition With Growth In Puppies And Positive Nitrogen Balance In Patients, *S. Forum* 18:356-357, 1967.

3. Wilmore, D. W., and Dudrick, S. J.: Growth and Development of an Infant Receiving All Nutrients Exclusively by Vein, *J.A.M.A.* 203:140-144 (Mar. 4) 1968.

4. Dudrick, S. J., et al: Long Term Total Parenteral Nutrition with Growth, Development, and Positive Nitrogen Balance, *Surgery* 64:134-142 (July) 1968

5. Dudrick, S. J. and Wilmore, D. W.: Long-Term Parenteral Feeding, *Hosp. Prac.* 3:65-78 (Oct.) 1968.

6. Wilmore, D. W., et al: Total Parenteral Nutrition in Infants With Catastrophic Gastrointestinal Anomalies, *J. Ped. Surg.* 4:181-189 (April) 1969.

7. Wilmore, D. W.; and Dudrick, S. J.: Effects of Nutrition On Intestinal Adaptation Following Massive Bowel Resection, *S. Forum* 20:398-400, 1969.

8. Conolly, W. B.; Murphy, J. B.; and Belzer, F. O.: Intravenous Feeding By An Arteriovenous Shunt, *S. Forum* 19:383-384, 1968.

9. Halversen, R. C.; Hogle, H. H.; and Richard, R.: Gastric and Small Bowel Fistulas, *Amer. J. Surg.* 118:968-972 (Dec.) 1969.

10. Border, J., in discussion, Dudrick, S. J., et al: Long Term Total Parenteral Nutrition with Growth, Development, and Positive Nitrogen Balance, *Surgery* 64:134-142 (July) 1968.

11. Feeler, E. M., and g. de Alva, W. E.: Infraclavicular Percutaneous Subclavian Vein Puncture. A Safe Technic, *Amer. J. Surg.* 118:906-908 (Dec.) 1969.

12. Weakley, S. D., Jr., and Mays, E. T.: Percutaneous Catheterization of the Subclavian Vein In Various Clinical Situations, *KMA Journal* 67:902-906 (Dec.) 1969.

Malignant Lip Lesions*

Robert C. Kratz, M.D.

The Davis mucosal advancement technique and Bousisson W-excision and Y-closure are the two most useful techniques in the management of lip lesions. Combined, the two techniques are useful in managing diffuse superficial cancer of the lip.

TECHNIQUES for the reconstruction of the lips have interested surgeons for many years. The purpose of this paper is to bring attention to several techniques which, when mastered, can adequately manage 95 per cent of the lip surgical problems which occur following excision of a lesion.

Following a reconstructive procedure, the lip should ideally be mobile and covered with mucosa on its inner surface and skin on its outer surface. There should be vermilion where the skin and mucosa meet which resembles a cupid's bow on the upper lip and a segment of an oval on the lower lip.



FIG. 1 Specimen of lower lip with localized infiltrating squamous cell cancer. Leukoplakia involves the remaining lip. Serial sections show three separate areas of squamous cell cancer.

A two millimeter skin punch biopsy instrument is used to perform a biopsy. The punch is rotated between the fingers until it has created a core three to four millimeters deep. The core is removed from the lesion with small pointed scissors and put in 10 per cent formalin for examination by the pathologist.

Lip lesions may be classified as localized, in which the remaining lip mucosa is normal and diffuse with usually one larger infiltrating area. The diffuse lesion is often misleading in that the cancer in situ is difficult to detect. Cancer in situ often is missed by the pathologist unless the surgeon requests serial sections of the tissue removed.



FIG. 2 Complete excision of the lower lip leaving only the commissures. There is a V-Y closure of the area beneath the infiltrating area.

It seems best to treat all lesions associated with leukoplakia as diffuse lesions and remove the entire area of leukoplakia along with the infiltrating lesion. It has on several occasions surprised me to find that a lesion was squamous cell cancer when it was removed and serial sectioned; however, the original biopsy diagnosis had been leukoplakia.

A procedure described by Davis[1] is very useful in the treatment of leukoplakia and diffuse superficial squamous cell cancer. If necessary, the mucosa of the entire lip may be removed, except at the commissures. Mucous membrane with its associated glandular structures is shifted forward and sutured to the skin creating a new vermilion. Very often it is well to remove a millimeter or more of the skin along with the vermilion since this junctional area is often involved with squamous cell cancer. A symmetrical portion of the lip is removed rather than create asymmetry of the lip by removing more from one side than the other. A W-excision of

Read before the Ninth International World Congress of Otolaryngology, Mexico City, November 14, 1969



FIG. 3 Repair of the lip using a combination of the Davis Lip Shave and the Bouisson W-Y procedure.

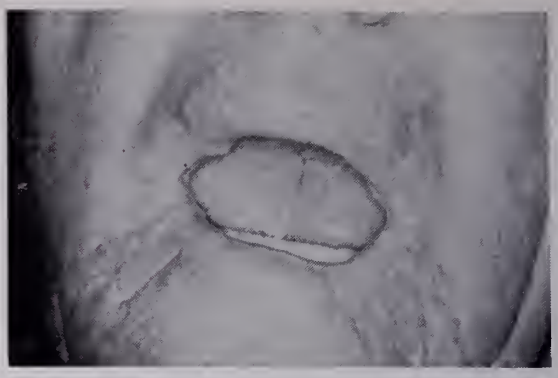


FIG. 4 Photograph of patient six months following the complete excision of the lower lip combined with a V-Y closure of an infiltrating area.

tissue is sometimes used in combination with mucosal advancement technique.

Seventy-five per cent of the lower lip lesions in the author's series were handled with a simple W-excision. The V-excision technique has been abandoned because it is wasteful of tissue and the scar is longer causing a depressed irregularity following healing and scar contraction. The W-excision was described first by Bouisson[2] and deserves more attention since it avoids a straight line scar.

A single-flap running upward and outward across the nasolabial fold with the base of the flap at the junction of the outer and middle third of the upper lip, was described by Estlander[3]. This flap of the upper lip is rotated 180 degrees into a defect of the lower lip.

Lesions of the upper lip are rarely seen. A procedure in which a flap is rotated 180 degrees from the lower into the upper lip was described by Abbe[4]. The pedicle may be much thinner than shown in Abbe's illustration and the vermilion may be completely cut through and approximated with the vermilion of the defect. This is possible because the arterial supply of the pedicle lies beneath the mucosa rather than the vermilion and skin. The stair step procedure described by Kratz[5] with excision of a Burow's[6] triangle from the nasolabial area is also a useful upper lip technique. Local flaps are best used in the management of lip lesions because they provide vermilion border, mucosa and innervated muscle. Large lesions involving the bone of the upper and lower jaws may be managed with flaps and tubes from distant areas. The bi-tubed pedicle flap described by Kratz and Poweleit[7] is a technique of special value when the mandible is involved.

References

1. Davis, J. S., "Chapter XXI, Surgery of the Lips (Cheiloplasty)," in *Plastic Surgery, Its Principles and Practice,* Philadelphia, P. Blakiston Son & Co, 1919, p. 510.
2. Bouisson: *Montpelier med* 21:541, 1864.
3. Estlander, J. A., *Rev mens de med et chir,* Paris 1:344, 1877.
4. Abbe, R. A., A New Plastic Operation for the Relief of Deformity Due to Douple Harelip, *Med Rec* 53:477, 1898.
5. Kratz, R. C., Management of Lip Lesions, *Arch. Otolaryn.* 78:803, 1963.
6. Burow, von Szymanowski: *Hanbach der operativen Chirurgie,* Braunshweig, Germany F. Vieweg u. Sohn, 1870, 277.
7. Kratz, R. C. and Poweleit, A., A Method for Handling Advanced Malignant Lesions of the Lip, *Arch Otolaryng.* 72:479, 1960.



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Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain and the United States have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives.

The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

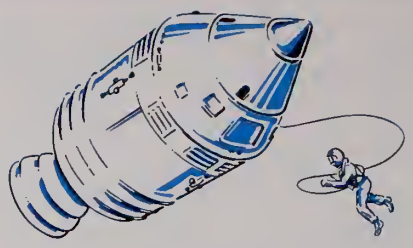
References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651:657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.



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SPECIAL ARTICLES

Kentucky Physicians' Response to a New Health Professional†

RALPH W. EICHENBERGER, M.D.*, WALTER I. HUME, JR., M.D.**,
KEENE A. WATSON, *M.D.*** AND ROSE MARIE HAWKINS, M.P.H.****

In this report of Kentucky physicians' responses to a new health professional a majority of them see a need for some type of new health worker. A significant number further express a willingness to employ one in their own practice. In general, they approve the proposed training program for a specific type of assistant, the Clinical Associate.

IN the 10 years since Hudson[1] first suggested the possible need for a new level worker to assist the physician in his clinical tasks a variety of programs have been developed attempting to answer this need. Few of these programs, however, have documented the need as expressed by the physician for this new worker who is supposed to assist him, and as was suggested by Hudson that this should be done.

Pediatricians have surveyed their own ranks to determine the extent of assistance rendered in their practice by ancillary personnel.[2] Internists have been analyzing their practice routines to try to sort out tasks which they might delegate to properly trained professional health personnel.[3] One other study attempted to canvass the physicians of a state concerning their reaction to the concept of a new health professional of the level of an assistant.[4]

An experiment carried out at the University of Kentucky Medical Center trained one assistant at the request of a practicing physician. A subsequent proposal that would expand the experiment to involve a number of students in a pilot training program and that would prepare the Clinical Associate in two-year, post-high school training to become a physician's assistant met with the cautious endorsement of the Executive Committee of the Kentucky Medical Association. The proposed idea and training program was then submitted to the entire membership of the Association through a special article in the Journal of the Kentucky Medical Association.[5] Following this a survey of the physicians' reactions to the proposed new health professional was undertaken.

Method

A three-part, 19-item questionnaire was submitted to members of the State Medical Association. Rather than ask for a set of responses to a general idea of the physician's assistant, reference was made throughout the questionnaire to the article in the Journal,[5] and the questions sought a response to the ideas and proposals concerning a specific, rather clearly defined figure, the Clinical Associate, and to a specific program, the one proposed by the University of Kentucky.

Part 1 of the questionnaire asked a minimum of identifying information, name, address, specialty and type of practice. Part 2 asked only one question, "In your opinion, is there a need for **some** type of new health person such as the Clinical Associate". If the answer was "no", the physician was advised that he could return the questionnaire without having to complete the last part.

Part 3 had several sub-sections. From physicians who responded affirmatively to a felt need for a new health worker additional information was sought, the extent of the felt need in their own practice, how much and what kind of training this person ought to have to be of assistance, and the general rules under which this person should function, among other things.

†*This study was made possible by support from the Ohio Valley Regional Medical Programs. The conclusions are those of the authors and do not necessarily reflect the position of the supporting agencies.*

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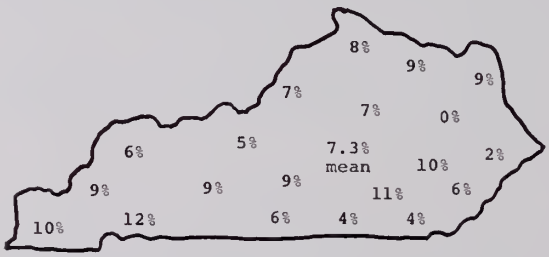
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In order to give every physician an opportunity to express his opinion on this subject the questionnaire was distributed to the total membership of KMA (2628) accompanied by a letter from the chairman of the Committee on Medical Education of the Association explaining the purpose and importance of the survey and requesting the cooperation of the members. Reliance for response from this group depended entirely upon this one mailed questionnaire.

At the same time, a 10 per cent representative sample of the membership was identified for more intensive follow-up. From a random start this sample was drawn systematically from the Kentucky Medical Association files which are stratified alphabetically by zip code number. A general geographic distribution of the sample was thus obtained by this method, as may be seen from the accompanying chart. (Fig. 1) Although we did not have a practicable means at our disposal for selecting the sample by practice specialty, general practitioners, who constitute 34 per cent of all physician members of the Kentucky Medical Association, were found to be represented by 36 per cent of our sample respondents.

FIG. 1

Geographic distribution of sample respondents as the percentage of total members of the Kentucky Medical Association by regions of the Commonwealth.



A 10 per cent sample selected systematically from a random start from membership files stratified alphabetically and by zip code number. November 1969.

Two additional procedures were utilized in eliciting a response from the sample group. Non-respondents after three weeks were sent a follow-up letter, reprint of the Journal article, and another questionnaire. If a response was still not forthcoming within another three weeks the physician was contacted by telephone and further urged to respond to the questionnaire. At no time however, was there indication given that the physician so solicited was in any way a special target that would perhaps bias his responses.

The results of this survey follow.

Responses

The response rate from the initial mailing to the entire membership and the sample was only 17 per cent. This was raised to 53 per cent for the sample group after the second letter, and another 20 per cent by subsequent telephone contact for a total of 73 per cent of the sample group. The responses from the sample of physicians were thus received in three more or less distinct lots. However, there was no statistically significant difference in the percentage of "yes" and "no" responses to the main question (Part 2) of the questionnaire in these three mailings. "Yes" responses were 57 per cent, 60 per cent and 66 per cent respectively [$X^2=0.82$, $p.> .05$].

Another 16 per cent (41 physicians), when contacted by telephone, promised to return their questionnaires but they were never received despite the fact that a second reprint of the article and a third questionnaire were mailed to these physicians upon their request. The remainder of the sample (11 per cent) could not be reached by phone for one reason or other despite repeated attempts.

Results

Responses from the Non-Sample:

Of the 413 non-sample members from whom a response was received, no part of the questionnaire was answered by 22, the explanation given was that the physician was retired, or in military service, or out of practice for graduate training, etc.

Of the remaining 391, 61 per cent replied that in their opinion there is a need for a new type of health worker. 38 per cent replied that there was no need. One physician said he was uncertain.

To a second question, 75 per cent of those expressing a general need further indicated that they felt a need in their own practice for some person such as the Clinical Associate. Twenty-five per cent felt no need. (Table 1)

In view of the small response rate from the non-sample membership and the more adequate data from the representative sample of physicians, the remainder of this report will deal only with the latter group.

Responses from the Sample:

Of the 262 physicians of the sample 191 responded, but four eliminated themselves as participants

TABLE 1

Kentucky physicians' expressed need for a new health worker.

Question	Non-sample Membership N = 2366		
	Yes	No	Total
In your opinion, is there a need for some type of new health worker such as the Clinical Associate?	240	151	391*
	61%	38%	99%
Do you feel any need in your own practice for some person such as the Clinical Associate?	172	58	230**
	75%	25%	100%

* Represents total respondents from the non-sample of the membership.

**Represents total respondents from the non-sample of the membership who answered yes to the basic question.

TABLE 2

Expressed need for a new health worker by a representative sample of Kentucky physicians.

Question	Sample n = 262 Yes	No	Total
In your opinion, is there a need for some type of new health worker such as the Clinical Associate?	117	70	187*
	63%	37%	100%
[95% confidence interval = 56-70%]			
Do you feel any need in your own practice for some person such as the Clinical Associate?	78	36	114**
	68%	32%	100%
[95% confidence interval = 59-76%]			

* Represents all respondents from the sample of the membership

**Represents all respondents from the sample of the membership answering "yes" to the basic question.

by reason of retirement or other inactivity and did not answer the questionnaire. Of the 187 respondents (71 per cent of the sample) 63 per cent replied that there is a need for some type of new health worker. (The 95 per cent confidence interval is 56-70 per cent.)

The remainder checked "no" and returned the questionnaire without further response, although 10 of the negative respondents added an additional note to explain more specifically why, in their opinion, there was no need, or that such a person should not be trained. (Table 2)

The physicians (117) who expressed a need for a new health worker were then asked, "Do you feel a need in your own practice for such a person as the Clinical Associate?". Three did not respond to the question explaining it was not applicable since they were not personally in a practice situation. Of the remainder, 68 per cent responded in the affirmative. (The 95 per cent confidence interval = 59 — 76 per cent.) Seventy-one of the 78 physicians responding in the affirmative further indicated they would definitely (29) or possibly (42) hire such a person as the Clinical Associate.

"Informal" Assistants

Expression of a felt need for a new type of health worker was made in spite of—or perhaps because of—the fact that 73 per cent of physicians replied they already had in their present practice some one or ones whom they would classify as an "informal" assistant defined in the article as his "right hand man" or "girl Friday". These were represented by several professions or levels of training: RN's 30, LPN 15, Nurses' Aide 5, Medical Assistant 19, other 19.

Acceptance of a New Health Worker

One question frequently raised in any discussion of the physician's assistant type of person is his acceptance by patients, by other allied health professionals, and by the physician's colleagues. Kentucky physicians were asked to express their opinion regarding the degree of acceptance this new health professional might expect. On a scale from zero (totally reject) to nine (fully accept) they rated patient and colleague acceptance at a median of six and their staff at a median of seven.

The Function of the Clinical Associate

The University of Kentucky program to train a new assistant for the physician would produce an activity-performer to serve a markedly expanded clinical role vis-a-vis the patient. Physicians were asked which of the proposed activities the new health worker should be trained to perform. Their responses give an indication of the clinical functions these physicians feel they might delegate to a lesser trained health worker, and of their concurrence with the training program as presently conceived.

Eighty-two per cent of physicians who express the need for a new health worker believe this person should be trained to take a complete medical history

TABLE 3

Functions for which the Clinical Associate should be trained, as seen by Kentucky physicians.

The question: In your opinion, should the Clinical Associate be trained to perform the following activities?

	% Yes	n = 117* % Unrestricted	% Restricted
Take a complete** medical history?	82	43	39
Perform a complete** physical examination?	46	9	37
Make a preliminary judgment about the diagnosis, or state a working diagnosis?	57	24	33
Prescribe further investigations on his own?	48	12	36
Administer or prescribe therapy? (per certain limitations as in the article)	57	46	11

* Represents all respondents from the sample of the membership answering "yes" to the basic question.

**defined as "complete as is expected of a senior medical student"

("as complete as is expected of a senior medical student"). Almost half of those would place some restrictions on this activity, but our questionnaire did not spell out what those restrictions would be nor did the respondents do so. Only eight per cent would not see this as a function of the assistant.

However, only 46 per cent believe this new person should be trained to do a complete physical examination and 37 per cent would impose some restrictions on this activity. Forty-two per cent were emphatic that they would not want this person for this clinical activity at all.

Should the Clinical Associate be trained to make a preliminary judgment of the diagnosis in order to proceed to the further investigations which might need to be done? Fifty-seven per cent were in favor of this, 24 per cent said yes unreservedly, 33 per cent more would spell out some restrictions, and 24 per cent would not see this as a function for which the assistant should be trained.

Forty-three per cent would not want the person to be trained to order or perform further investigations on his own. Forty-eight per cent believe he should be so trained, but 36 per cent would place certain restrictions on this activity.

It had been stated in the previous article that the greatest objections to the proposed functions of the Clinical Associate would be to his administering or prescribing treatment. Nevertheless, it was proposed that under carefully regulated situations he be authorized to "administer and prescribe therapy, but only and always as the agent of the physician." Very generally, then, some limitations were spelled out as they might be applied, "certain prescriptions or treatments would be prohibited, some might be conditional, others might be permitted, all would ultimately be subscribed to in writing by the physician".

Contrary to expections 57 per cent of those in favor of some type of new health worker thought the Clinical Associate should be trained to administer or prescribe therapy. Forty-six per cent were satisfied with the limitations as spelled out. Eleven per cent specified further limitations they would impose. Thirty-four per cent would not under any circumstances want this a part of the training.

TABLE 4

Educational pre-requisites for the Clinical Associate as seen by Kentucky physicians.

Minimum educational background:	No.	%
High School	32	28%
2 Yrs. College	42	35%
Bachelor's Degree	10	8%
R.N.	20	18%
Certified in a Profession	2	1%
Not Ans.	12	10%
Totals*	117	100%

*represents sample respondents answering "yes" to the basic question.

TABLE 5

Academic to Preceptorship ratio of the training program of the Clinical Associate as seen by Kentucky physicians.

Academic : Preceptorship	No.	%
1/4 : 3/4	8	6%
1/3 : 2/3	9	7%
1/2 : 1/2	52	44%
2/3 : 1/3	9	7%
3/4 : 1/4	20	19%
Not Ans.	15	13%
Totals*	117	100%

*represents sample respondents answering "yes" to the basic question.

Authorization to Function

A solution to another troublesome question concerning this new health worker was proposed in the referred to article. Rather than licensing by law, the legal authorization and responsibility for the Clinical Associate to function would rest with the physician whose associate he is. To the query, "Would you be satisfied with this solution . . ?", 56 per cent said they would, 14 per cent said they would not. Some indicated further that they thought the new worker should be licensed or certified or both licensed **and** certified (18 per cent).

Education of the Assistant

The remainder of the questionnaire asked the physicians answering Part 3 concerning the educational prerequisites, the length of the training period, and the ratio of academic and preceptorship components they thought the program should have.

The minimum educational background which should be required for entering upon this type of training was thought to be high school by 28 per cent, two years of college by 35 per cent, a bachelor's degree by nine percent, R.N. by 18 per cent, and certified in some other professions one per cent (Table 4)

The University of Kentucky Clinical Associate program proposes a 24-month training period. Seventy-one per cent of the respondents agreed this was adequate; 11 per cent did not. In a subsequent question seven respondents thought 12 to 18 months training would be sufficient, eight thought the graduate should qualify for an Associate degree from a community college and eight that they should qualify for a baccalaureate degree. One respondent would demand that they qualify for a master's degree.

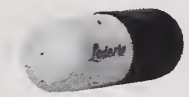
Forty-four per cent thought the ratio of academic to preceptorship training should be half and half and they concur with the proposed program in this. Six per cent thought it should be 1:3; seven per cent, 1:2; seven per cent 2:1; and 19 per cent thought it should be academic three parts to one part preceptorship. (Table 5)

Doctor, after all we've been through together...

abscess
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amebiasis
anthrax
bacillary dysentery
bartonellosis
bronchitis
bronchopulmonary infection
brucellosis
chancroid
diphtheria
endocarditis
genitourinary infections
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
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pertussis
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TABLE 6

Responses of general practitioners and specialists in Kentucky to the survey questionnaire.

	General Practitioners n = 68*			Specialists n = 123*			X^2
	Total	Yes	%	Total	Yes	%	p. > .05
NEED							
Need for a new health worker	68	35	51%	123	82	67%	4.26
Personal need expressed	35**	27	77%	82**	51	62%	2.46
Might employ such a person	35	23	65%	82	48	58%	0.52
Now employs "informal" assistants	35	28	80%	82	58	71%	1.08
FUNCTIONS							
Take a history	35	34	96%	82	62	75%	7.72
Perform a physical examination	35	22	62%	82	31	38%	6.21
Make a preliminary judgment or diagnosis	35	26	74%	82	40	49%	6.49
Do a diagnostic work-up	35	20	57%	82	36	44%	1.72
Treatment	35	19	54%	82	48	58%	0.18
EDUCATION							
High School		9	25%		23	28%	0.06
Minimum 2 Yrs. College		16	45%		26	32%	2.09
Pre-requisite Bachelor Degree	35	4	11%	82	6	7%	0.53
R.N.		4	11%		16	19%	1.13
Other		2	6%		11	14%	1.47

* Represents all sample respondents to the questionnaire.

**Represents sample respondents answering "yes" to the basic question.

Availability of Candidates

Because the University of Kentucky program is committed to the principle of accepting candidates who would be submitted by Kentucky physicians, the last question attempted to ascertain how many physicians could, or thought they might be able to, submit candidates for training. Twelve per cent responded that they definitely could and 37 per cent more that they probably could.

Assistants for the Generalist or the Specialist?

Training programs that have developed in the past 10 years have been variously proposed to meet the needs of the general practicioner or the specialist. Of 40 programs reviewed in October 1969, five were structured to prepare only the generalist assistant, five others would prepare the generalist as well as a variety of specialist assistants. The remainder were all types of more or less restricted specialty assistants.

The University of Kentucky proposes the training of a type of assistant who would be a generalist first but able to go on to specialize through an elective pathway in a preceptorship. However, since the proposed program is committed to responding to the needs as they exist, one may analyse the expressions of need according to the specialty of Kentucky physicians sampled. Small numbers in the many sub-specialties represented in this sample preclude drawing valid inferences for each of them individually from this study. However, general practitioners and the specialists as a group may be compared both as to felt need and in their differences in responses to other questions of the survey. (Table 6)

Expression of Personal Need by Specialty Type

General practitioners as a group express less need for a new type of health worker than do the specialists, 51 per cent of generalists to 67 per cent of specialists and this is a statistically significant difference [X^2=4.26, p.> .05].

However, it is pertinent to ask, is this an expression of need of a new worker for someone else or is there a personal felt need sufficiently strong that the physician would employ such a person if he were available?

Although 77 per cent of general practitioners compared to 62 per cent of specialists feel a personal need for a new health worker, and 65 per cent of generalists might be in the market to hire one compared to 58 per cent of specialists, these differences are not statistically significant.

How differently do general practitioners and specialists view the function of the assistant? Ninety-six per cent of generalists who responded to all the questionnaire would see the Clinical Associate trained to take a history compared to 75 per cent of specialists. [X^2=7.72, p> .05] Sixty-two per cent of general practitioners and 38 per cent of specialists would want the Clinical Associate trained to do a physical examination [X^2=6.21 p> .05] but only 11 per cent of general practitioners and eight per cent of specialists would see him doing the exam without some restrictions.

Seventy-four per cent of general practitioners and 49 per cent of specialists would want the Clinical Associate trained to make a preliminary judgment about a diagnosis. Forty-three per cent of generalists and 29 per cent of specialists would place some restrictions on this activity.

But in the activities of doing a diagnostic work-up and in being trained to administer or prescribe therapy there is not significant difference between general practitioners and specialists. Fifty-four per cent of generalists and 58 per cent of specialists would want the Clinical Associate to be trained for the latter function.

Also, in the matter of legal authorization for the Clinical Associate to function there is no significant difference between the two groups. Fifty-one per cent of generalists and 58 per cent of specialists would be satisfied to leave the legal responsibility with the Associate's physician.

Educational Requirements

The educational prerequisites as seen by general practitioners and specialists are also listed in Table 6. There are some slight differences between the opinions of the two groups but none of them are of statistical significance.

Type of Practice and Need for a New Health Worker

Forty-seven per cent of the sample population were in solo practice and 54 per cent of physicians in this type of delivery set-up felt a need for some new type of health worker. Twenty-five per cent were in a partnership and 60 per cent of them expressed such a need. Sixteen per cent were in group practice and 67 per cent of these physicians felt a need for a worker such as the Clinical Associate. (Table 7) These are not significant differences between the three categories, however. [$X^2_3=0.60$, $p>.05$]

TABLE 7

Kentucky physicians' expressed need for a new health worker according to type of practice.

Type of Practice	Sample n = 187* Total	Yes	%
Solo	90	49	54%
Group	31	21	67%
Partnership	48	29	60%
Academic	10	10	100%
Industrial	2	2	100%
Public Health	3	1	33%
Other	3	2	66%
	187	114	

*Represents all respondents from the sample of the membership.

Expressed Need by Year of Graduation

It has been presumed and was so stated by some physicians interviewed in the follow-up of this survey that later graduates from medical school would react more favorably to the idea of assistants than would older practitioners. Table 8 shows the responses of physicians answering Part 3 of the questionnaire according to the decade in which they were graduated.

It is true that those who have been in practice 40 to 50 years, almost two-to-one do not feel a need for a new type health worker. But four who have been graduated longer than that, three of whom are still in active practice, all express the need for some such person as the Clinical Associate to assist the physician.

TABLE 8

Kentucky physicians' expressed need for a new health worker, according to decade of graduation from medical school.

Decade	Sample n = 187* Total	Yes	%
1910-1919	3	3	100%
1920-1929	19	7	36%
1930-1939	28	19	64%
1940-1949	41	24	59%
1950-1959	66	45	68%
1969-1969	30	19	63%
	187	117	

*Represents all respondents from the sample of the membership.

It is also true that there is little difference among physicians graduating in the decades since then but they are almost two-to-one in their felt need for a new assistant.

Comparison with Wisconsin Physicians

The findings of this survey show some interesting similarities and contrasts with the study done in Wisconsin[1] although detailed comparisons cannot be made between the two for various reasons.

As Coye and Hansen point out, their study did not survey a randomly selected sample of the physician population and their findings are reported on only 27 per cent volunteer respondents. Also, the questions asked are not quite comparable in that theirs are, in one sense, less specific in that they seek to elicit a response to a hypothetical person and the functions he might perform. Our questionnaire, after an initial question that eliminates those who categorically reject the whole idea of a new type health worker, then seeks to elicit a reaction to a clearly defined figure, the Clinical Associate, and to a specific program that has been proposed. In another sense, the questions about the functions of the assistant in the former study are more specific in that they are broken down into finer detail and are difficult to recombine into general categories to be compared with ours.

The only data that are related and comparable are their responses to the general and personal felt need for some new type of worker by their respondents and those of our non-sample population. These two findings are remarkably similar. Sixty-one per cent of both groups express a general need and in the neighborhood of 42 per cent express a personal need. (The total respondents (391) of Table 1 must be used for the denominator of Kentucky physicians responding affirmatively to this question (172) to make the data comparable).

Comparison of other data, although interesting, would be no more meaningful than making com-

parison with our own non-sample population, and is not done here for the reason cited earlier.

Conclusions

The response rate from the total membership is not surprising considering that the target population was the busy, practicing physician. The telephone follow-up revealed a number of well-known interrelated phenomena occurring in the physician's office, the daily receipt of an abundance of mail that is intercepted by very efficient secretaries who screen out anything that looks like more unnecessary paper work for the physician—including questionnaires. A not infrequent discovery, too, was a certain amount of apathy, perhaps more apathy than antipathy, toward this whole idea of a new type of health worker.

Nevertheless, an adequate response from the selected sample, which is representative geographically by design and representative as to specialty by chance, does allow for making some generalizations about Kentucky physicians' reactions to a new health professional.

A majority of physicians do see a need for a new type of health worker. This is not an expression merely of a general need, but a significant percentage feel a personal need for someone such as the Clinical Associate in their own practice.

Translated into round numbers, one can say that some 1400 Kentucky physicians probably feel such a need and that about 280 would commit themselves to employ such a person as the Clinical Associate and another 420 were not quite so definite but would possibly hire one were he available.

Specialists express more of a general need for a new type of assistant than do general practitioners, but there is no significant difference when it comes to expressing a personal need in their own practice.

There is no significant difference in expression of need according to the type of practice of physicians whether in a solo, group, or partnership arrangement. Physicians who have been in practice 40 to 50 years do not see a need for a new health worker but for all others the need is uniformly strongly expressed.

The majority of Kentucky physicians would be satisfied to leave the legal authorization of the Clinical Associate's function to rest with the physician whose agent he would be.

There would be no serious problem of acceptance of a new health professional by either their patients or their colleagues and less so by their staff, in the opinion of these physicians.

Kentucky physicians generally agree they would want to see the Clinical Associate trained to perform the functions proposed for an expanded clinical role. But they clearly show preference for some activities over others and there is a difference depending on one's specialty.

The general practitioner would see the Clinical Associate trained to take a history, do a physical examination with some restrictions, and make a preliminary diagnosis more than would the specialist. Prescribing further diagnostic studies on his own and carrying out treatment procedures are seen equally by generalists and specialists as legitimate functions for which the Clinical Associate should be trained.

In summary, one may interpret from the number of positive responses that a clear majority of Kentucky physicians are in general accord with the role as it is spelled out for the Clinical Associate but with certain cautious reservations.

Their opinions about the educational prerequisites and the training experience are varied, as might be expected in an uncharted field such as this. The majority feel that the trainee should come to the training with two years of college and that the course ought to be another two years, one year of which would be in an academic setting, the second in a preceptorship.

There is another smaller group who feel that high school followed by the two year course would be adequate, and in this they concur with the program as proposed by the University of Kentucky. A still smaller number would set the prerequisites as an R.N. certificate and two additional years of a half academic, half preceptorship course.

About half of the physicians believe they might be able to submit a candidate for the training program.

References

1. Hudson, C. L., Expansion of Medical Professional Services with non-Professional Personnel, *J.A.M.A.*, 176:839-41, June 10, 1961.

2. Bergman, A. B., Probstfield, J. L., Wedgwood, R. J.: Task identification in pediatric practice, *American Journal of Diseases of Children*, 118:459-68 September, 1969.

3. Allied Health Professional Survey of the American Society of Internal Medicine. San Francisco, California (Personal Communication).

4. Coye, R. D., Hansen, M. F., The "Doctor's Assistant." A Survey of Physicians' Expectations. *J.A.M.A.*, 209:529-33, July 28, 1969.

5. Eichenberger, R. W., Hamburg, J., Ewer, R. W., Kotheimer, T. G.* The Clinical Associate: Rationale for Training a New Health Professional. *Journal of the Kentucky Medical Association*, 67:677-680, September, 1969.

Erratum

*Thomas G. Kotheimer, Jr. is not M.D. as he was erroneously designated by the publishers of this article.



Vell, Dr. Cunningham! I was just telling Herbert should talk to you about my allergy. irst my nose starts to tickle and..."

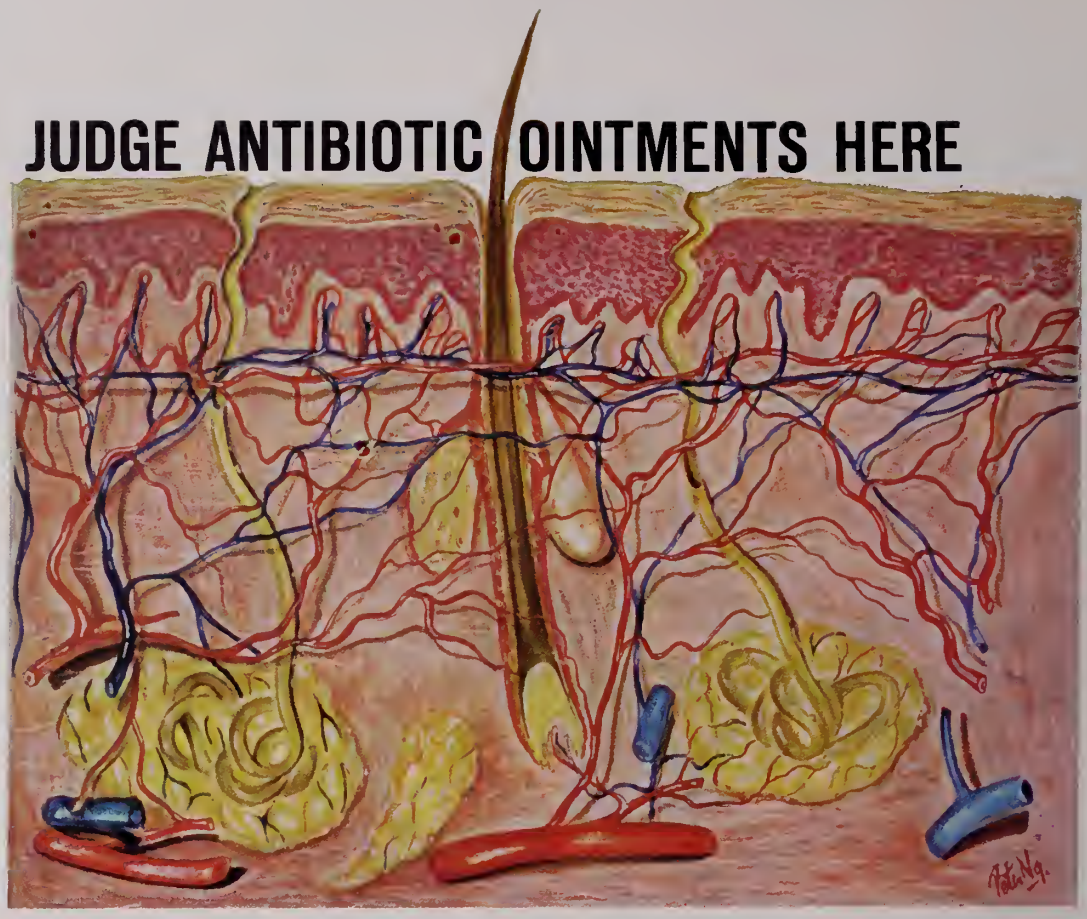
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1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

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EDITORIALS

Peptic Ulcer—Anything New?

It is profitable now and then to inquire what changes occur that should alter our accepted concepts relating to any disease. Such changes sometimes, but rarely, are rapid, even revolutionary; but more often gradual and almost imperceptible. It has been so in the case of our knowledge concerning peptic ulcer. For instance, 20 years ago there was a movement to abandon the term "peptic" and better define just the type of ulcer under consideration. Present literature however makes about as frequent of the term as before.

Continuous and exhaustive research and study has been carried on for more than 30 years to better understand and define the etiology of the disease and some encouraging new approaches have been published during the past year but we are still far from knowing. The best that has been offered is that the factors are numerous and varied. "Stress ulcer" has come to the fore in recent years but just what is meant by the term is vaguely understood and what successful means may be used for its prevention and cure has not been explained. Ulcer does not seem more frequent in psychosomatic or psychotic persons than in the general population. The previously overworked "ulcer diathesis" has all but fallen into disuse. Nor are age limits now accepted; it occurs from infancy to extreme senility, though not of course with the same frequency as in young adult and middle ages.

Duodenal ulcer has generally been accepted as occurring from four to ten times as frequently as gastric ulcer. Autospy findings have always tended to refute this accepted thought and clinical experience now tends to considerably narrow this ratio. Better roentgenological techniques have perhaps been the principal factor in this change.

A well recorded history is, and always has been, the most helpful means of suggesting diagnosis of ulcer. Physical findings generally contribute little. X-ray examination remains our principal reliance in establishing diagnosis but even this is often deceptive. Endoscopic study continues to be of great help in questionable cases especially for gastric lesions. The fibroscope has not justified its early claims as a means of entering the duodenum.

Gastric analysis has been regarded by many physicians as of secondary or even negligible value in establishing diagnosis of either gastric or duodenal ulcer, but of greater service in differentiating benign from malignant gastric lesions. Modifications such as fractional specimens, histamine or histolog stimulation and recording of PH values have increased the usefulness of actual titration of gastric contents and it continues to be a reliable aid in diagnosis, in guiding therapeutic measures and, in malignant gastric lesions, offering some help in prognosis. Tubeless gastric analysis has seemed to us to have very limited or even uncertain usefulness.

Whether much progress has been made during the last decade or two or three in treatment of peptic ulcer is debatable. Many methods have come and gone. A few remain fairly stable. The beneficial effects of cabbage juice, milk or no milk, foreign protein and hormone injections, enterogastrone, complete bed rest, focal infection and vaccines, psychiatric counselling, change of occupation, climate and environment have proved to be disappointing. The anticholinergics have largely fallen into disuse because there is no substantial evidence that they significantly reduce the acid secreting function of the stomach while at the same time occasionally producing adverse reactions such as altering the function of the stomach and urinary bladder. It has been a long time since we have seen "Sippy diet" ordered on a chart. The strict insistence upon milk and other bland or pureed foods with very gradual increase of allowance over a three to six week period has gradually given way to the present permissiveness of practically unrestricted diet. Fairly convincing reports have appeared to the effect that either method accomplishes the same end, with, of course, some edge in favor of the more liberal regimen.

Three long accepted principles of treatment however, do hold steadfast in the minds of most physicians: 1) relief from mental and emotional tension, 2) frequent fairly small feedings and, 3) the liberal and frequent use of antacids, which is still thought to be the most effective means of providing rapid healing of the ulcer. Antacids have changed, if not progressed, from baking soda to combination powders with magnesium trisilicate regarded as not effective, to aluminum jels, to polysaccharides and other classes of acid neutralizers and inhibitors. Today a generally accepted medical regimen consists of the most effective relief of

stress and tension, using mild sedatives and tranquilizers if deemed necessary; frequent feedings—varying from one to three hours—of a very liberal variety of relatively simple foods; antacids at one to three hour intervals as deemed necessary to control acidity. Gastric analysis, measuring the amount of secretion and the level of acidity proves to be a helpful guide to the use of antacid therapy. Anticholinergics may seem helpful clinically but are now not generally regarded as essential. Re-X-ray of the intestinal tract at three to six week intervals for observation of progress in healing, especially of gastric lesions, should not be neglected.

Because medical treatment has so often been disappointing in the quick repair and prevention of recurrences, and because of surgical advances offering greater promise of relief than previously, most physicians, after complications or intractible chronicity or recurrences, are more prone to recommend surgical treatment than ever before. There is no question that well selected and executed surgery for the above listed circumstances offers more than it did even a few years before. Yet it often proves to be far short of a satisfactory or permanent solution. The general experiences of about 20 per cent of surgical disappointments perhaps still maintains despite the best judgment and technique the surgeon can offer.

What then can we claim as substantial progress in this 50 years from the Sippy to the Inglefinger eras? A great deal. We have learned much about the life history of peptic ulcer, what it is not and some thing of what it is. The teamwork of the researcher, the pathologist, the roentgenologist, the clinician, and the surgeon has taught us all very much. There is frustration that we have not learned more, but with the present prompt dissemination of medical knowledge we should cover a great deal more ground in the next 10 year period than ever before. The principal agencies working in this area are the Digestive Disease Foundation, the National Institute of Arthritis and Metabolic Diseases, the American Gastroenterological Association, the American College of Gastroenterology and the Veterans Administration. The researches and clinical experiences of these groups are much more coordinated than ever before. Perhaps we need a national foundation for the study of gastrointestinal diseases, the principal of which is peptic ulcer.

SAM A. OVERSTREET, M.D.

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KMA Annual Meeting Dates

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Precautions: As with other thyroid preparations, an overdosa may cause diarrhea or cramps, nervousness, tremors, tachycardi vomiting and continued weight loss. These effects may begin aft four or five days or may not become apparent for one to three week Patients receiving the drug should be observed closely for signs thyrotoxicosis. If indications of overdosage appear, discontin medication for 2-6 days, then resume at a lower dosage level. patients with diabetes mellitus, careful observations should be ma for changes in insulin or other antidiabetic drug dosage requi ments. If hypothyroidism is accompanied by adrenal insufficiency, Addison's Disease (chronic subcortical insufficiency), Simmonds Disease (panhypopituitarism) or Cushing's syndrome (hyperadre alism), these dysfunctions must be corrected prior to and duri SYNTHROID (sodium levothyroxine) administration. The dr should be administered with caution to patients with cardiovascu disease; development of chest pains or other aggravations of c diovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction.

Side effects: The effects of SYNTHROID (sodium levothyroxir therapy are slow in being manifested. Side effects, when they occur, are secondary to increased rates of body metabolism: swe ing, heart palpitations with or without pain, leg cramps, and weig loss. Diarrhea, vomiting, and nervousness have also been observe Myxedematous patients with heart disease have died from abr increases in dosage of thyroid drugs. Careful observation of t patient during the beginning of any thyroid therapy will alert t physician to any untoward effects.

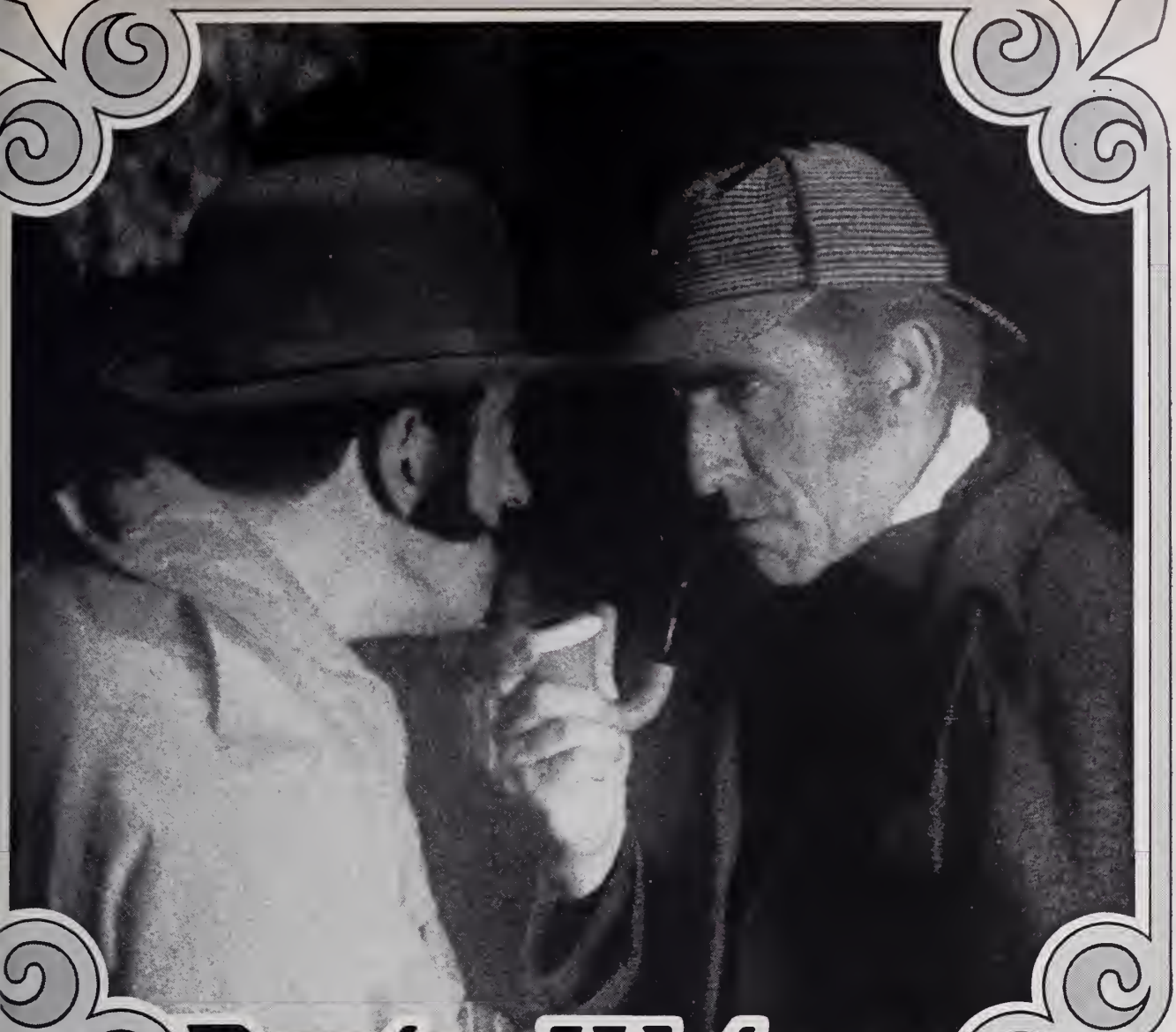
In most cases with side effects, a reduction in dosage followed a more gradual adjustment upward will result in a more accur indication of the patient's dosage requirements without the appe ance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHRC (sodium levothyroxine) TABLET is equivalent to approximately grain thyroid, U.S.P. Administer SYNTHROID tablets as a sin daily dose, preferably after breakfast. In hypothyroidism with myxedema, the usual initial adult dose is 0.1 mg. daily, and may increased by 0.1 mg. every 30 days until proper metabolic balanc attained. Clinical evaluation should be made monthly and measurements about every 90 days. Final maintenance dosage usually range from 0.2-0.4 mg. daily. In adult myxedema, start dose should be 0.025 mg. daily. The dose may be increased to mg. after two weeks and to 0.1 mg. at the end of a second two wee The daily dose may be further increased at two-month intervals 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., mg., 0.5 mg., scored and color-coded, in bottles of 100 and 500. In tion: 500 mcg. lyophilized active ingredient and 10 mg. of Manni N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chlor Injection, U.S.P., as a diluent.

SYNTHROID (sodium levothyroxine) INJECTION may be admi tered intravenously utilizing 200-400 mcg. of a solution contain 100 mcg. per ml. If significant improvement is not shown the foll ing day, a repeat injection of 100-200 mcg. may be given.

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Doctor Watson exposes a double agent

; on the Embankment. Two figures emerge into silhouette against a oed street lamp. The flare of a match reveals the profile of Sherlock lmes. As he lights his calabash, his companion speaks:

y Jove, Holmes, that amazing intuition of yours has proved right in. What we're looking for is a single entity. I thought we were ling with several others—even twins. But now—I'd say we've covered a double agent."

ell me more, Watson, and be quick about it!"

atson withdraws a folded paper from inside his greatcoat, and ds aloud from it):

ne key to the whole cypher is SYNTHROID (sodium levothy-ine)"...

hh! Watson, not so loud! You'll alert our quarry."

atson continues): "A single entity that serves two functions."

master stroke, Watson."

llow along, Holmes. In the neighborhood of 95% of the circulat- thyroid hormone is levothyroxine—T_4 as you call it. T_4 is bound hyroxine-binding proteins in the serum. It becomes available only dually to tissue cells—as free thyroxine."

"Is that why there's such a smooth, predictable response, Watson?"

"Quite! With agent T_4, SYNTHROID, the chances of a precipitous rise in metabolic rate are lessened."

"But how does 'free' thyroxine fit into the picture?"

"Well, Holmes, you might call it the tissue thyroid hormone—because 'free' thyroxine (that is, thyroxine not bound to protein) is active at the tissue level. It is gradually released from thyroxine-binding proteins. Each daily dose of SYNTHROID is mostly bound to thyroid-binding proteins, and slowly released as 'free' thyroxine—the form in which it is metabolically active."

"Magnificent, Watson! So protein-bound thyroxine is the major form of circulating thyroid hormone, and it is released as 'free' thyroxine. And that's why SYNTHROID is able to simulate the normal process so artfully. Q.E.D."

"Not so fast, Holmes. SYNTHROID works for the *physician*, too. Because its dosage is more precisely controllable, and because response is so smooth and predictable, the *doctor* gets fewer phone calls in the wee hours from agitated patients. Both parties get more sleep!"

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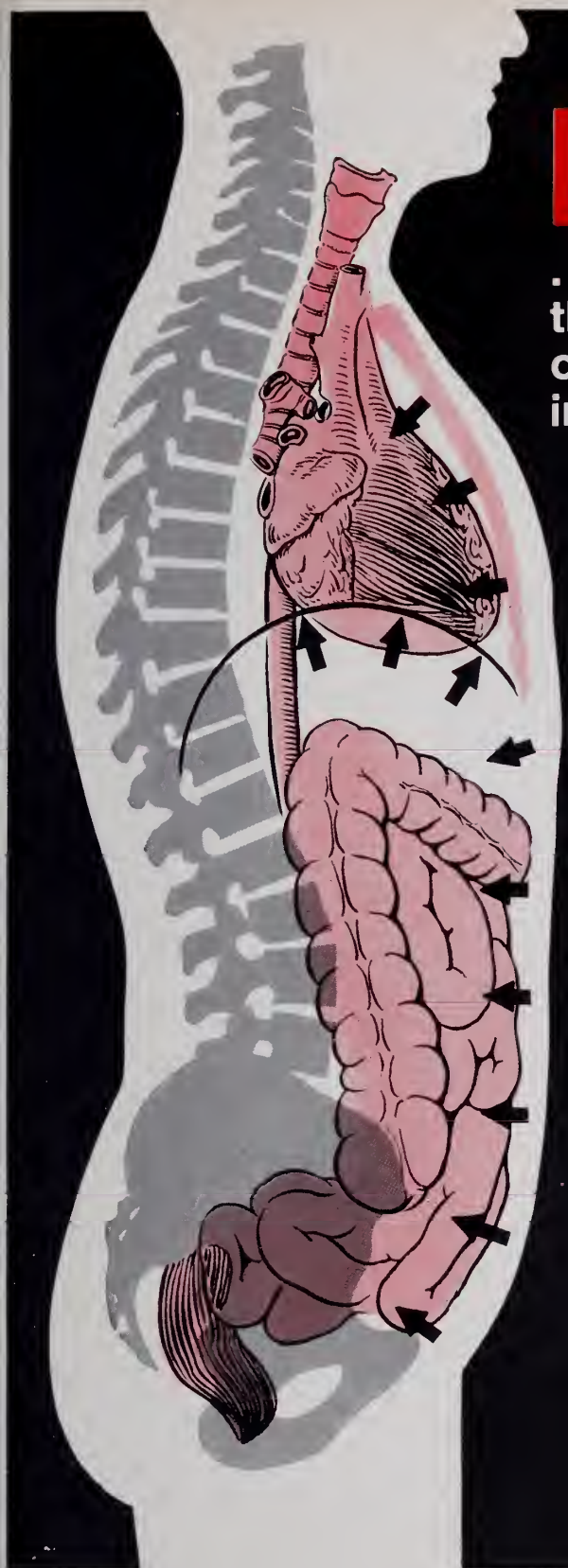
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(2) Samuel N. Workman, M.D.
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(3) Charles W. Neville, Jr., M.D.
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Composition: Each capsule contains 50 mg. danthron N.F. and 60 mg. dioctyl calcium sulfosuccinate.

Dosage: Adults and children over 12—one or two capsules daily. Children 6 to 12—one capsule daily. Give at bedtime for two or three days or until bowel movements are normal.

Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT SECTION

1970 Annual Meeting — Kentucky Medical Association

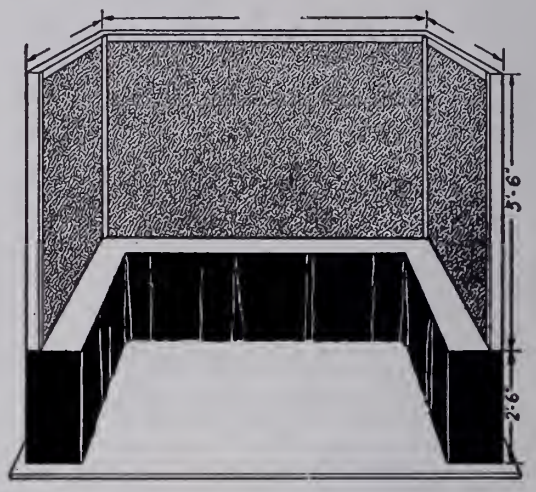
Convention Center — **Louisville, Kentucky** — **September 22, 23, 24**

Fill Out and Mail to:

T. R. MARSHALL, M.D., Chairman
Committee on Scientific Exhibits
Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, Kentucky 40205

Applications for space should be received before July 1, 1970

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....
   Institution (if desired): .....
   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)
   Charts and Posters.... Photographs.... Drawings.... X-rays ....
   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
   Amount of total wall space needed? .....
   Back wall .....Side walls (All side walls are 4') .....
   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided to you in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....
Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

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Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

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URISED also is useful as a prophylactic measure prior to urinary tract instrumentation or operation. In acute fulminating infections, URISED may be used for symptomatic relief while awaiting specific laboratory diagnosis. May be combined with specific therapy where indicated.

Effects: Rapid relief of pain, relaxation of smooth muscle spasm through parasympatholytic action of atropine and hyoscyamine; pus cell content decreased.

Administration and Dosage:

Adults: Two tablets, orally, four times per day, followed by liberal fluid ihtake.

Children: One-half the adult dose.

Acute cases: Initially two tablets every hour for three doses, followed by the recommended daily administration.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Side Effects: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

How Supplied: Bottles of 100, 500 and 1,000 tablets.

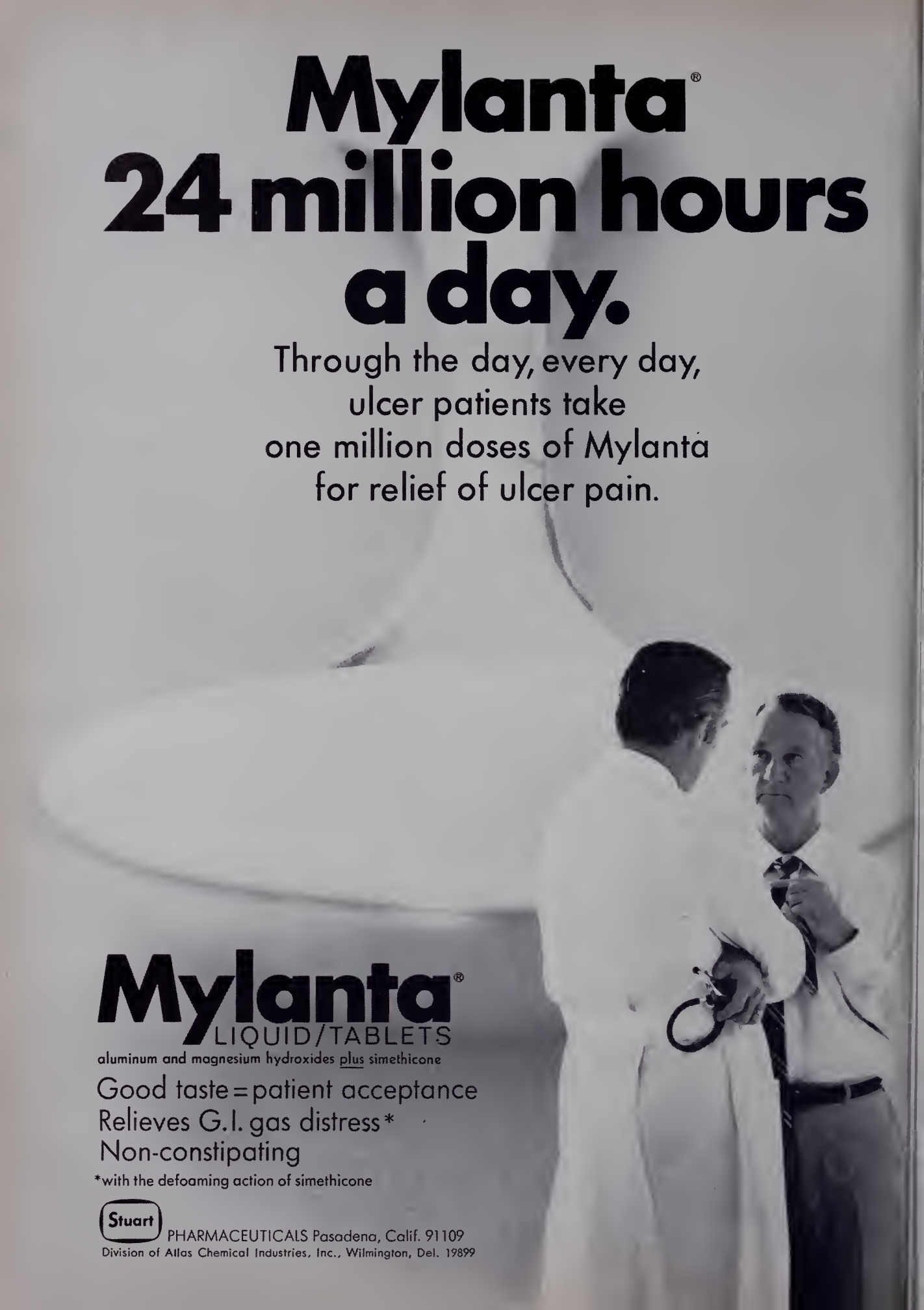
References: (1) Sands, R. X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M. J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest. Med. 42:30-32, 1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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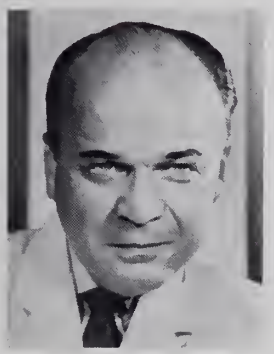
*with the defoaming action of simethicone

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ORGANIZATION SECTION

Outstanding Scientific Program To Feature 21 Guest Speakers For KMA Annual Meeting September 22-24 in Louisville

Highlighting the 1970 KMA Annual Meeting will be presentations and discussions by 21 prominent guest speakers who have accepted invitations to appear on the scientific program of the three-day session, which will be held September 22-24 at the Convention Center, Louisville, according to Walter L. Cawood, M.D., Ashland, KMA president.



Doctor Lillehei

The KMA Scientific Program Committee has worked to arrange an outstanding program which will interest physicians in every medical specialty. Guests of the Association, specialty group speakers, and local physicians will speak at the four general sessions on a number of medical topics. A few of the themes chosen for the general session presentations are "Emergencies," "Cardio-Pulmonary Resuscitations," "Industrial Medicine," and "Tuberculosis."

The Crackerbarrel Session, initiated at the 1969 meeting, will again be featured on this year's program and will include many individual informal discussions.

Other features of the 1970 session include meetings of the 16 specialty groups, two meetings of the KMA House of Delegates, the President's Luncheon, technical and scientific exhibits, an Orientation Program for new members and meetings of the Woman's Auxiliary to KMA.

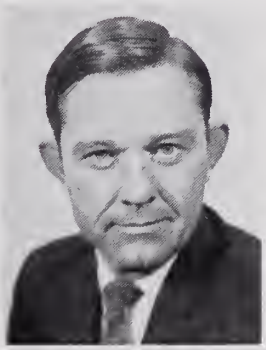
Invited by the Association to participate in this year's Annual Meeting are C. Walton Lillehei, M.D., New York, N.Y.; Lawrence E. Meltzer, M.D., Philadelphia, Pa., and Vernon N. Houk, M.D., Atlanta, Ga.

Doctors Lillehei and Meltzer will speak at the September 23 morning and afternoon general sessions dealing with "Cardio-Pulmonary Resuscitation." Doctor Houk will speak on "Chemotherapy of Tuberculosis" and participate in a panel discussion on the "Problems in TB Therapy" on Thursday morning, September 24.

Doctor Lillehei, who is chairman and surgeon-in-chief of the department of surgery at New York Hospital and Cornell Medical Center, received his M.D. degree in 1942 and his Ph.D. in surgery in 1951, both from the University of Minnesota Medical School. A noted surgeon, Doctor Lillehei has won numerous awards, a few of which were for his "inspired teaching of cardiology" in such countries as Pakistan, India, Chile, Colombia, the Philippines and Taiwan.



Doctor Meltzer



Doctor Houk

A 1952 graduate of the University of Louisville School of Medicine, Doctor Meltzer has been director of the section of clinical investigation, Research Institute and director of the coronary care unit, University of Pennsylvania Medical Center since 1962. Before going to the University of Pennsylvania, Doctor Meltzer taught physiology and pharmacology at U of L.

Doctor Houk, deputy chief of the Tuberculosis Program at the National Communicable Disease Center, Atlanta, is a 1954 graduate of George Washington University School of Medicine. He formerly was chief of the pulmonary disease section of the V.A. Hospital, Houston, Texas.

Further details on other speakers and highlights of the KMA Annual Meeting will be carried in future issues of *The Journal.*

Exhibitors Urged To Make Plans

All physicians interested in presenting scientific exhibits at the 1970 KMA Annual Meeting are urged to make their plans and application to do so, according to T. R. Marshall, M.D., Louisville, chairman of the KMA Scientific Exhibits Committee.

Exhibits need not be expensive or professionally constructed, but should have a good subject and be of teaching value. This year's Annual Meeting will be held September 22-24 at the Louisville Convention Center. An application for the scientific exhibits is on page 322. For further information, please contact the KMA Headquarters Office.

AMA Annual Convention To Offer Many Features For Physicians

The 119th Annual Convention of the American Medical Association will be held June 21-25 in Chicago, Ill. and will feature fireside conferences, general scientific meetings, section programs, research forum, medical motion pictures and hundreds of scientific and industrial exhibits. The headquarters hotel for this session will be the Palmer House.

This year's convention will be particularly exciting to Kentucky physicians as Robert C. Long, M.D., Louisville, is a candidate for AMA President-Elect.

Topics for the four general sessions will be the Comatose Patient and the Diagnosis of Death, Conception Control and Abortion, Delivery of Health Care, and the Role of the Physician in Family Life and Education.

Six special sessions have been scheduled again this year. These will include the Suicidal Patient, Occupational Diseases, Plastic and Maxillofacial Surgery, Neurological Surgery, Drug Interactions and Adverse Reactions and Nuclear Medicine. Gerald D. Dorman, M.D., AMA president, urges all physicians to make their plans and reservations now for this exciting meeting.

Emergency Care Course Offered September 16-19 in Lexington

The American Academy of Orthopaedic Surgeons will sponsor a four-day advanced course on emergency care and transportation of sick and injured persons September 16-19 at the University of Kentucky Medical Center, Lexington.

Faculty members of the University, members of the Fayette County Medical Society and others will conduct lectures and practical sessions during the course, which is designed for experienced first aid personnel interested in advanced training with emphasis on the instruction of others in emergency care.

For information write William K. Massie, M.D., c/o Lexington-Fayette County Civil Defense, Loudon House, Castlewood Drive, Lexington, 40505.

Award Presented To KEMPAC At AMA/AMPAC Seminar

The 14-member Kentucky delegation that attended the AMA/AMPAC Workshop on Public Affairs in Washington, D.C. February 28-March 1 was presented an AMPAC award in recognition of KEMPAC's outstanding contribution to the political action movement and the political leadership demonstrated during the past year.

Speaking at the seminar was U.S. Senator Mike Mansfield, Montana; U.S. Senator Hugh Scott, Pennsylvania, and U.S. Senator Edward R. Gurney, Florida. These prominent figures of government emphasized the need for political involvement at the local level and the importance of broad-scale financial and personal commitment to candidates.

Those in attendance from Kentucky were Hoyt D. Gardner, M.D., member of AMPAC Board of Directors, and Mrs. Gardner, president of the Woman's Auxiliary to KMA; C. Kenneth Peters, M.D., chairman of the KEMPAC Board, and Mrs. Peters; John C. Quertermous, M.D., president-elect of KMA; Lee C. Hess, M.D., KMA trustee; Fred C. Rainey, M.D., vice-chairman of the KEMPAC Board; John S. Oldham, M.D., KEMPAC Board member; Max P. Jones, M.D., KEMPAC Board member; Carl J. Brueggemann, M.D., KEMPAC Board member; Carl Scott, M.D., KEMPAC Board member; Mrs. C. C. Lowry, KEMPAC Board member; John E. Trevey, M.D., chairman of the Legislative Committee of the Fayette County Medical Society, and Gilbert L. Armstrong, KMA director of field services.

Dr. Haynes Is Named Dean At U. L. Medical School

Douglas M. Haynes, M. D. was named dean of the University of Louisville School of Medicine by the University's trustees on April 15. Doctor Haynes, who has served on the University's faculty for 15 years, was named interim dean last May to fill a vacancy caused by the resignation of Donn Smith, M. D. as dean.

A 1946 graduate of Southwestern Medical College, Doctor Haynes became chairman of the department of obstetrics and gynecology at U of L in 1957 and served in that post until he became acting dean last year.

Doctor Haynes serves on several KMA committees, including the Committee on Plans and Development and the Committee on Medical Education.

Board of Health Appts. Made

Joseph R. Miller, M.D., Benton, was recently appointed to the Kentucky State Board of Health by Governor Louie B. Nunn. Doctor Miller served as KMA Vice-President from the western section of the State from 1962 to 1963.

In another appointment, George P. Archer, M.D., Prestonsburg, a former KMA president from 1963 to 1964, was named chairman of the State Board of Health.

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The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

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(meprobamate)
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Philadelphia, Pa.

Photo professionally posed.

I'll scream if I don't get away!

Highlights of 1970 KMA Interim Meeting Presented

Stimulating addresses and informative discussions were two of the highlights of the 1970 KMA Interim Meeting held April 8 and 9 at Kentucky Dam Village State Park, Gilbertsville. Termed a highly successful session by members and officers of the Association, the two-day meeting was attended by 286 physicians, their wives and guests.

In addition to the outstanding presentations of the guest speakers, the Interim Meeting included meetings of the KMA Board of Trustees, Woman's Auxiliary and an Orientation Program for new members.

Russell B. Roth, M.D., Erie, Pa., speaker of the AMA House of Delegates, addressed the KMA audience at the opening session April 8 on "Health Care in the Seventies." Doctor Roth reviewed the problems physicians will face in providing medical services in the next decade.

During the dinner preceding the opening session several presentations were made to members of the Association. KMA President Walter L. Cawood, M.D., Ashland, presented a charter to the Pennyrile Medical Society, the first official multi-county society organized in Kentucky. Gabe A. Payne, Jr., M.D., Hopkinsville, accepted the charter as President of this Society.

Robert C. Long, M.D., Louisville, as President of the AMA Education and Research Foundation, presented checks to the representatives of the two medical schools in Kentucky. Douglas M. Haynes, M.D., Louisville, interim dean of the University of Louisville School of Medicine, accepted a check for $9,895.19 for the U of L. The assistant to the Vice-President of the University of Kentucky College of Medicine, Tom F. Whayne, M.D., Lexington, accepted a check for $3,677.56 for U.K.

The Thursday morning sesion opened with a panel discussion on the timely topic of Peer Review. Moderated by Doctor Cawood, the panel consisted of John W. Koon, Louisville, executive secretary of the Kentucky Farm Bureau Federation, Vincent Santare, M.D., Munster, Ind., and Marvin A. Bowers, Jr., M.D., Louisville, chairman of KMA's Claim and Utilization Review Committee.

Another informative panel discussion dealt with the Physician's Assistant, a topic of much interest to today's physician. This panel, moderated by Walter I. Hume, Jr., M.D., Louisville, included Robert W. Ewer, M.D., Galveston, Texas and D. Robert Howard, M.D., Durham, N.C. who are both in charge of the physician's assistant type of program at the University of Texas Medical Branch and Duke University School of Medicine, respectively.

A luncheon session featuring an address by J. Ed McConnell, Louisville, closed the session. As President of Kentucky Physicians Mutual, Inc. and Blue Cross Hospital Plan, Inc., Mr. McConnell delivered a highly entertaining and informative talk on Blue Cross and Blue Shield in Kentucky.

Physician Attendance Listed For Spring Orientation Program

Forty-six physicians attended the Tenth KMA Orientation Program for new members April 8 during the Interim Meeting at Kentucky Dam Village State Park, Gilbertsville, according to Carl Cooper, M. D., Bedford and C. Wyatt Norvel, M.D., co-chairmen of the KMA Committee on Orientation.

This year's program was extensively redesigned with an emphasis on brevity and informality. Program innovations included a detailed slide presentation on KMA and a question and answer period at the conclusion of the program.

The next Orientation Session is scheduled to be held September 21 in Louisville, just prior to the opening of the 1970 KMA Annual Meeting. Details of the program will be run in the August issue of *The Journal*.

Those physicians who attended this April 8 program are listed below. The KMA Headquarters Office should be contacted if the name of an attending physician has been inadvertently omitted from the list.

James E. Adams, M.D., Paducah
Douglas R. Alvey, M.D., Franklin
Wm. Thomas Anderson, M.D., Salyersville
Julio Arce, M.D., Alexandria
W. G. Begley, M.D., Bowling Green
Jack D. Bland, M.D., Henderson
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Carl B. Caplinger, M.D., Hopkinsville
James A. Clarke, M.D., Madisonville
Samuel Cooper, M.D., Louisville
John A. Crook, Jr., M.D., Henderson
Paul E. Davis, M.D., Paducah
Alfredo V. Echiverri, M.D., Paris
Walton M. Edwards, M.D., Louisville
Ralph W. Eichenberger, M.D., Lexington
Adalberto J. Fernandez, M.D., Hazard
Veryl F. Frye, Jr., M.D., Somerset
Jim K. Goodrum, M.D., Bowling Green
Allen J. Hamon, M.D., Carlisle
Charles E. Hogancamp, M.D., Paducah
Glenn E. Hogancamp, M.D., Paducah
Hal E. Houston, M.D., Murray
J. Jeff Johnson, II, M.D., Paducah
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David Leeper, M.D., Symsonia
Anthony F. Leger, M.D., Harlan
Lucretia Little, M.D., Madisonville
R. Leroy Little, Jr., M.D., Madisonville
Aureliano Martinez, M.D., Dayton
R. Wathen Medley, Jr., M.D., Owensboro
Wm. Raymond Meeker, M.D., Lexington
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Augustin Sierra, M.D., Henderson
Valentino Simpao, M.D., Calhoun
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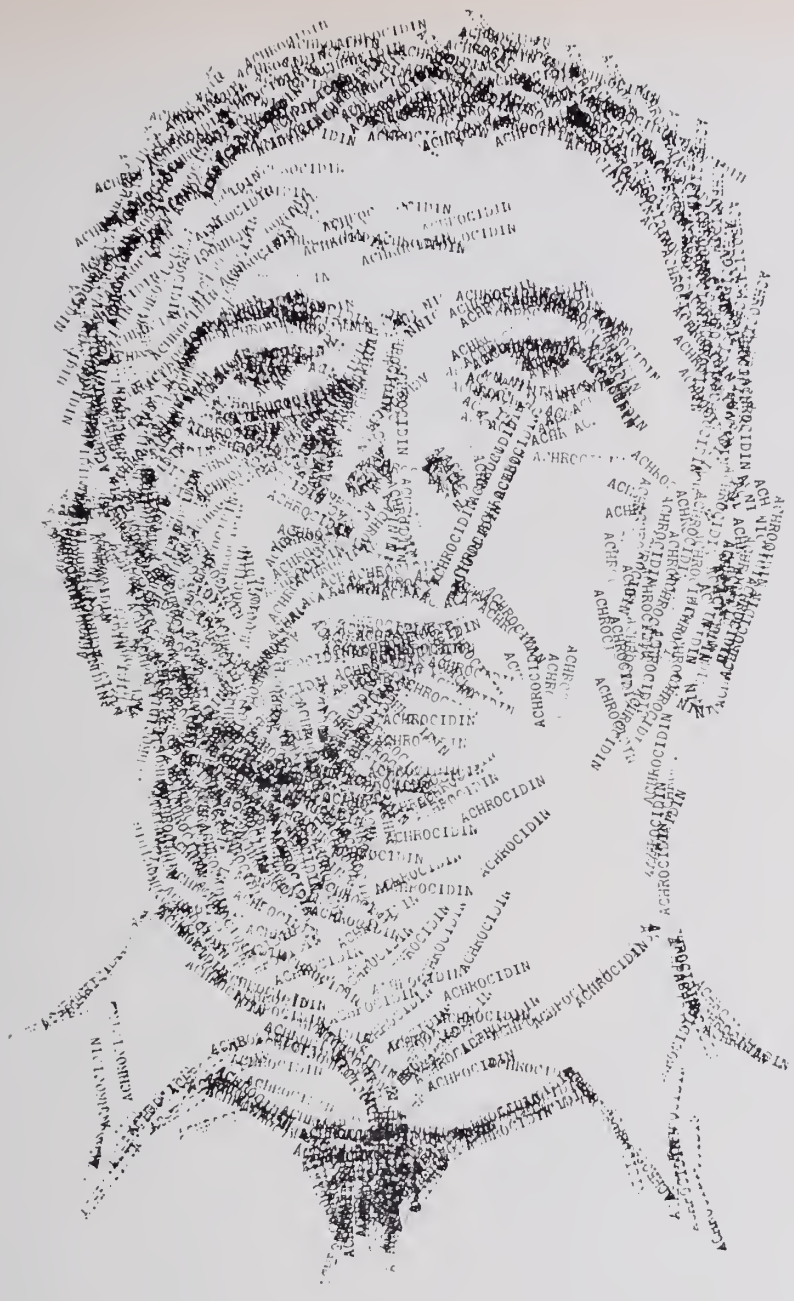
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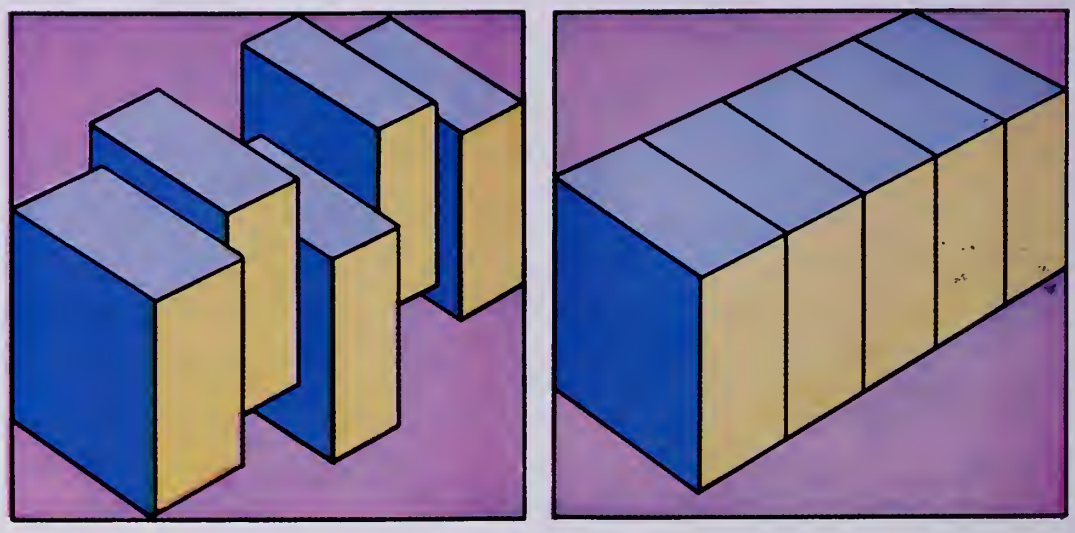
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MESSAGE FROM THE PRESIDENT



AMA Convention

Please try to attend the AMA Annual Convention June 21-25 in Chicago, the hustling, bustling city. There are splendid restaurants for good food. The weather in June is good for the family to boat or visit the many attractions Chicago has to offer, such as concerts, museums, theaters, zoos and art galleries. Show your AMA Journal to the family for these possibilities, including the tours offered through the Woman's Auxiliary to AMA.

Continuing medical education remains difficult for all physicians because of too much to do in too little time. To keep up during this period of a rapidly expanding volume of knowledge does require some effort. The many programs planned during the 119th Annual Convention are varied. There is something for you as a general practitioner or as a specialist. Your attendance is urged. Besides the many scientific programs, there are many scheduled activities involving the AMA House of Delegates and Board of Trustees and the reference committees which exist to discuss problems in medicine and their possible solutions today.

Your support of Bob Long for President-Elect of the AMA is earnestly sought whether you attend the meeting in Chicago or remain at home. Please contact any delegates that you know to support Bob. The practice of medicine remains Bob Long's "first love" evidenced by 23 years in the very busy practice of obstetrics and gynecology. He has served well for Kentucky, his profession and his community. Active in the Kentucky Medical Association, Bob Long's work with AMA began in 1956 as a member of the AMA House of Delegates and increased in 1963 when he was elected to the Board of Trustees of the AMA. For Bob to win would be a particularly important feather in the cap of us Kentuckians. More importantly, he would render the type of leadership that is needed for service to medicine in Kentucky and the United States.

Walter L. Cawood

Schering

After only one year:

Administered to more people than live in Lexington, Covington, and Owensboro.*



Injectable Garamycin®

brand of gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Lexington, Covington, and Owensboro is 192,500. (Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

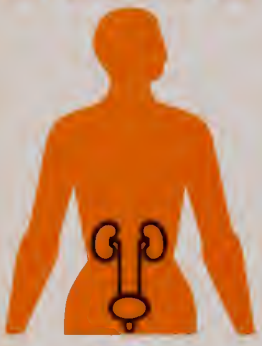
Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections[1,2]

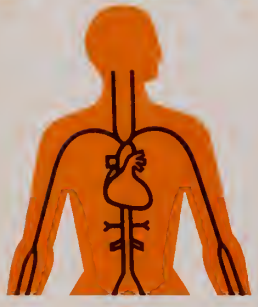
GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Schering

Over 95% gram-negative pathogens sensitive*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains / Number of strains tested — Antibiotics*							
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
Aerobacter aerogenes	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
Klebsiella aerobacter group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
Klebsiella, all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
Pseudomonas aeruginosa	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
Proteus, indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
Proteus mirabilis, indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
Proteus, unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
Escherichia coli and all other *Escherichias*	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
Paracolobactrum, all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
Coliform bacteria	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070
Gram-positive (included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus,* coagulase-positive	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph—*S. aureus,* unspecified	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August,1969).[6]
Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.
Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.
Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.
It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable Garamycin®

brand of gentamicin sulfate injection

Schering

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/ Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin in gram-negative urinary and pulmonary infections, Arch. Int. Med. *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., and Smith, J. K.: Gentamicin in the treatment of pulmonary infections, J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a new aminoglycoside antibiotic: Clinical and laboratory studies in urinary tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clinical experience with gentamicin, data from 12 German clinics, in Gentamicin: First International Symposium, Paris, January 1967, Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Laboratory and clinical investigation of gentamicin, *ibid.,* pp. 62-74. (6) Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, H.: Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommended in Package Insert.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28 S-029

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 1-65. This 19-year-old married white girl was under the care of a private physician. Her prenatal course was apparently uncomplicated. The EDC was 2/20/65. Total weight gain during this pregnancy was 20 pounds. She was admitted to the hospital at 3:20 a.m., 2/26/65, having contractions that began at 10:00 p.m. the 25th. Vaginal examinations revealed the cervix two fingers dilated, thin, membranes intact, cephalic presentation at 0 station.

Temperature was normal on admission; BP was 128/68. Urinalysis revealed sp. gr. 1.008, 3 + albumin and many RBC. Contractions became painful and at 4:35 a.m. she was sedated with 50 mg Demerol, 20 mg Largon IV. Vaginal examination at this time revealed the cervix 2-2½ fingers dilated fetal vertex at plus 1 station, the FHT were good. BP was 130/70. She received 25 mg Demerol 10 mg Largon IV at 5:55 a.m. when she complained of pain in her chest.

At 6:10 a.m. examination revealed a rim of cervix and the fetal vertex at plus 1 station. BP 170/102. She received 5 cc 50 per cent Mag Sulfate IM at 6:25 a.m. and her BP was closely checked. At 6:35 it was 160/98. At 6:45 it was 160/88, and at 7:00 her BP was 158/88.

The cervix was completely dilated at 9:30 a.m. The membranes were ruptured in the delivery room at 10:15 a.m. after administration of saddle block anesthesia. A 6 lb., 15 oz girl was delivered with outlet forceps at 10:47 a.m. in good condition with Apgar of 8. The placenta was expressed, it was complete and the uterus was explored and cervix checked. The midline episiotomy was repaired and blood loss estimated 200 cc. A Foley catheter was left in the bladder.

At 11:45 a.m. she complained of severe chest pain. Her BP 150/90, PR 64. She received 50 mg. Demerol IM at 11:30. BP—130/72. She was typed and cross matched for blood at 12:30. BP—122/70, PR 88 and she slept some. She received 500 cc whole blood at 4:00 p.m. Some clots were expressed from the uterus and the bleeding was described as slightly heavy. She again complained of chest pain. Gelusil 1½ oz. was given plus codeine IM.

At 6:30 her BP was 90/60 and she again complained of chest pain. She was examined by her physician; 1000 cc D5W was given IV at 8:30. BP was 100/80, lungs normal, heart regular, no murmurs, rate 100. She was somewhat restless during the night and still complained of pain in the chest. The BP was 146/96. At 4:00 a.m. she received 25 mg of Demerol IM.

At 4:30 p.m. the BP was 146/106, PR 112. Patient rose in bed and suddenly became ashen, pulse unobtainable, BP was unobtainable and breathing apparently ceased. An anesthesiologist in the hospital immediately started resuscitation. Neosynephrine, 4 cc of 1 per cent was added to the IV and her physician was called. When he arrived in approximately 20 minutes the patient was breathing and her pulse was stronger. A cardiologist was called in consultation. A portable chest x-ray was obtained and read as: opacification of the left lung field, probably representing edema and fluid. There was some widening of the upper mediastinal area which is probably on the basis of this fluid although the possibility of a tumor mass cannot be eliminated.

The cardiologist arrived at 5:40 a.m. and the EKG that was taken was read as sinus tachycardia, nonspecific S.T. segment depression, no other abnormalities. Levophed was used to support the BP. The patient had a convulsion at 6:20, lost consciousness for approximately three minutes and received artificial respiration during this period. Thiocortef was given. Her BP was 80/40. She had another convulsion and stopped breathing. The head was massaged, oxygen was administered, but the patient expired around 7:00 a.m.

An autopsy was obtained.

Autopsy Record

General Appearance: This is the unembalmed body of a well-developed, well-nourished white female appearing the stated age of 19. The anterior abdominal wall is flaccid consistent with recent gestation. There are no other external signs of note.

Peritoneal Cavity: Upon entrance into the peritoneal cavity approximately 55 ccs of serous light amber clear fluid is encountered interpreted as within normal limits for postpartum state. The uterus is identified having the appearance of a typical post-gestational uterus. There is congestion and edema of the uterine adnexal structures interpreted as within normal limits for the post-gestational phase. The coils of the small and large bowel are free. The epiploic foramen is open. The duodenal folds are present. The liver margin is flush with the costal border in the right mid-clavicular line. The diaphragm arches on the left to the fifth rib; on the right to the sixth interspace.

Pleural Cavities: Upon entrance into the left pleural cavity unclotted blood is encountered. On

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Brief Summary of Prescribing Information— 9-9/22/69. For complete information consult Official Package Circular.

Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

Usual Dose: 1 tablet b.i.d.

Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

BRISTOL BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

The antihypertensive therapy that is easy to live with.*

When successive blood pressure readings confirm essential hypertension, consider Salutensin for:

Easy-to-live-with control. Gradual reduction of blood pressure leading to decisive, comfortable control is the common clinical response.

*Salutensin is usually well-tolerated (however, serious side effects can occur; see adjacent column for brief summary of prescribing information).

Easy-to-live with dosage. Two tablets a day usually achieves control. One to two tablets a day often maintains control without need for additional antihypertensive agents.

Easy-to-live with cost of therapy. The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.



the right no free blood is encountered.

Lungs: The right lung is within normal limits of consistency and crepitation. The left lung is the site of irregular atelectasis resultant from the accumulation of gross blood in the pleural cavity.

Transverse Pericardium and Heart: The transverse pericardium itself is free of excess fluid with no blood present in the pericardial sac. The heart intrinsically is negative including the heart valves. The significant pathological process is identified in the ascending aorta. Approximately 1 cm. cephalad to the aortic valve leaflets is a smooth rounded fusiform dilatation of the aorta. This area presents itself for approximately 3 cms along the ascending aorta involving almost the entire ascending aorta extending up to the beginning of the arch. There is identified on the intimal surface of this bulge an area of performation of the lining of the aorta. This is interpreted as the site of leakage. The area of dilatation is identified as an aneurysm of fusiform shape combining sacculation and dissection. The dissection of the blood column extends cephalad along the arch of the aorta into the descending thoracic and abdominal aorta so that the entire aorta is the site of a longitudinal cleavage in which blood clot is demonstrable throughout. Additionally, at multiple points along the length of the aorta the blood clot has dissected its way into the adventitia of the aorta and into the surrounding adventitious soft tissue. This results in extravasation of blood in the subparietal pleurae bilaterally. This is extremely pronounced cephalad in the apices of the thoracic cavities and along the roots of the great vessels as well as along the larynx and the esophagus. Additionally at approximately the level of the fourth rib on the left and the retroparietal pleural hemorrhage has produced performation of the overlying parietal pleurae and blood has penetrated openly into the left thoracic cavity as previously noted. All of the blood clot encountered appears to be of approximately the same age. This refers to the clot in the aneurysm proper, along the length of the aorta, in the retroparietal pleural soft tissue spaces. It is not possible upon careful dissection to establish areas of lamination or concentricity in an effort to establish age. The aorta in addition to the above findings is the site of curious fragility of the intima. This structure appears thinned, pale white in color, remarkably friable and "brittle", very easily fragmented. The structure also along its entire length appears narrowed. The structure is probably consistent with atresia of aorta or hypoplasia.

The remaining findings were within normal limits.

Gross Anatomical Diagnoses

(1) Recent pregnancy with recent viable delivery.

(2) Postpartum, puerperal death.

(3) Aneurysm, ascending aorta, etiology undetermined.

(4) Dissecting aneurysm, length of the aorta.

(5) Ruptured, aneurysm, soft tissue retro-pleural, bilateral posterior mediastinal.

(6) Hematothorax, left, subsequent to #5.

(7) Possible true coarctation of the aorta.

(8) Possible hypoplasia (atresia) of the aorta with pseudo-coarctation.

(9) Absence, other significant gross pathological findings.

Correlation of the findings of the aorta in this case might indicate a true coarctation of the aorta especially in view of the site of the aneurysmal occurrence. However with the narrowing of the aorta along its length in the pattern of "tubular coarctation" the area between the aortic valve and the arch might be referred to as a pseudocoarctation.

Significant Microscopic Findings: Sections consist of multiple areas taken through the aorta and the area of the aortic aneurysm. Histologically the aorta in these sections is represented by the customary intimal, medial and adventitial components. Sections of the clot are identified.

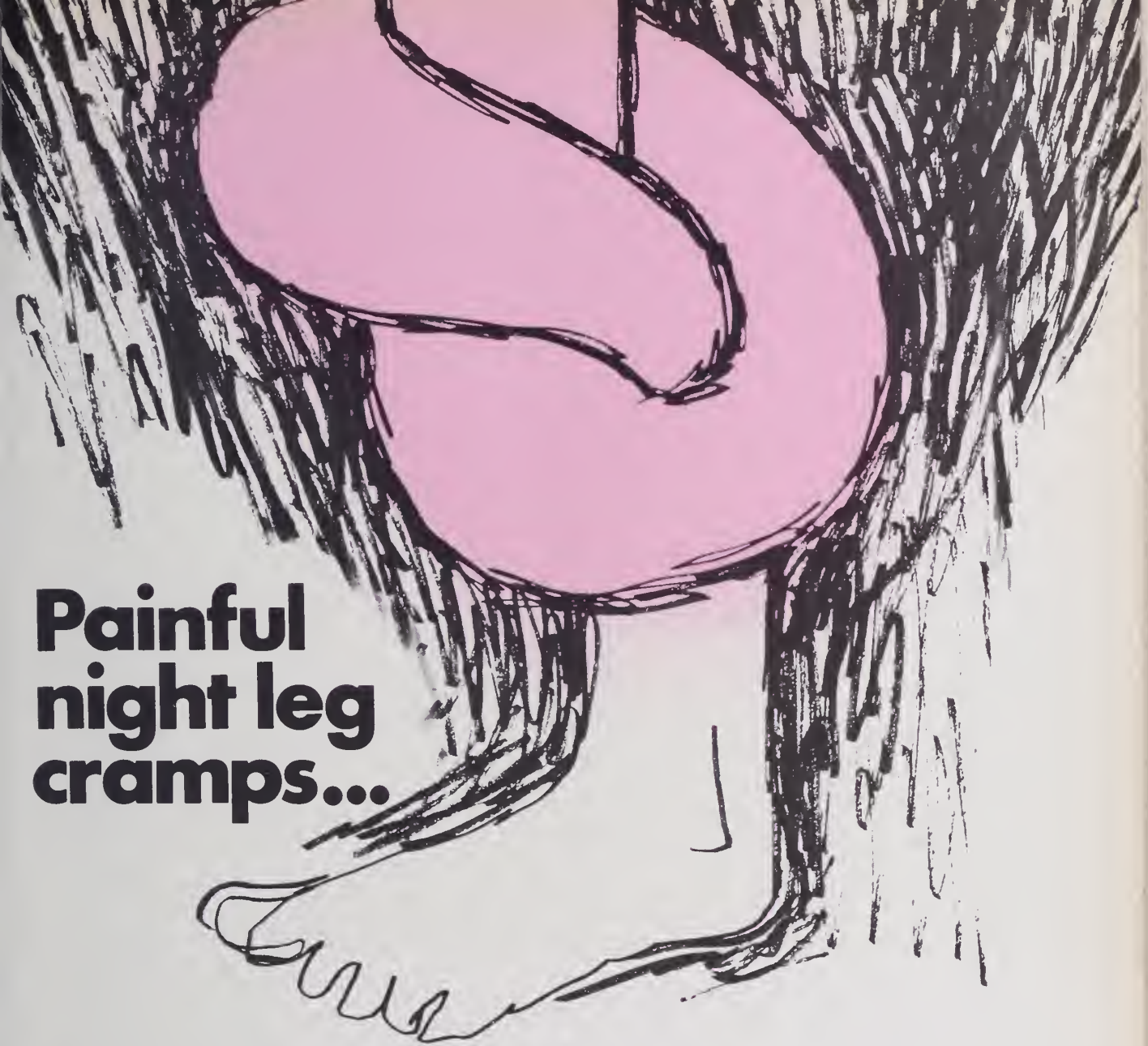
Final Anatomical Diagnosis: Aneurysm of the Ascending Aorta Probably Congenital with Rupture.

Comment

The Committee ruled this an obvious indirect obstetric death, unpreventable. The true cause of death would most certainly have been missed had the autopsy not been obtained. In a review of the literature, Mendelson[1] found 200 cases of coarctation of the aorta without operation. A maternal mortality of seven per cent occurred. Abdominal delivery has been recommend by Burwell and Metcalfe[2], when the history, signs or symptoms of aneurysmal rupture are present. However it would seem that cesarean section would be best unless vaginal delivery could be swiftly accomplished.

References

1. Mendelson, C. L.: *Cardiac Disease in Pregnancy*, Philadelphia, F. A. Davis. 1960.
2. Burwell, C. S. and Metcalfe, J.: *Heart Disease in Pregnancy*, Boston, Little Brown and Co. 1958.



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WHAT'S NEW

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Selected Aspects of the Management of Portal Hypertension

John W. Schaefer, M.D.*

Portal hypertension is defined as an abnormally elevated pressure within the portal venous system. The hemodynamic alterations are complex and incompletely understood, but usually obstruction to portal blood flow can be demonstrated. One way of classifying portal hypertension is based on the site of obstruction in relation to the hepatic sinusoids. Thus, vascular obstruction at the pre-sinusoidal location is seen with portal vein thrombosis and hepatic lesions involving primarily the portal tract areas, e.g. schistosomiasis. Post-sinusoidal obstruction occurs in most types of cirrhosis where regenerative nodules and fibrosis displace and compress hepatic veins. Constrictive pericarditis and hepatic vein thrombosis are examples of extrahepatic conditions producing post-sinusoidal portal hypertension. Diffuse sinusoidal compression can be identified in most forms of hepatic disease as an additional component to vascular resistance. By far the most common form of portal hypertension in adults in this country is seen in patients with hepatic cirrhosis.

Existence of portal hypertension can be suspected in patients with chronic liver disease especially in those with demonstrable portal collateral veins, splenomegaly or ascites. The presence of esophageal varices is convincing additional support. However, definitive diagnosis requires measurement of portal pressure directly at the time of surgery or by catheterization of the vestigial umbilical vein. Portal pressure can also be accurately assessed by determination of splenic pulp pressure or wedged hepatic vein pressure except in cases with pre-sinusoidal obstruction.

The development of esophageal varices is the most important consequence of portal hypertension. Elevated portal pressure may also lead to congestive splenomegaly with hypersplenism and play an important role in the development of ascites. Furthermore, the development of porto-systemic shunts contributes to the occurrence of hepatic encephalopathy and perhaps to the syndrome of spontaneous bacteremia of the cirrhotic.

Hemorrhage from esophageal varices is an ominous complication. In patients with cirrhosis the initial bleed carries a 30-50 per cent mortality rate. Demonstration of varices does not necessarily identify them as the source of upper intestinal bleeding. Approximately half of the alcoholics with varices who present with upper intestinal tract hemorrhage will be bleeding from a lesion other than varices. The most frequent alternate cause is hemorrhagic gastritis, but occasionally bleeding occurs from a peptic ulcer or lacerated mucosa at the esophagogastric junction, the Mallory-Weiss syndrome[1].

Since it is uncommon at esophagoscopy to observe active bleeding from a varix, the diagnosis of variceal hemorrage rests heavily on the exclusion of other possible bleeding lesions. As soon as the bleeding patient stabilizes, a barium x-ray study will usually show varices, if present, and give valuable information on the presence or absence of peptic ulceration. Endoscopy with modern fiberoptic

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instruments is a safe and even more reliable way to confirm existence of varices. In addition the procedure allows one to inspect the stomach for hemorrhagic gastritis a frequent source of bleeding that cannot be evaluated by x-ray examination. Therefore, accurate diagnosis of the bleeding site requires use of both early endoscopy and x-ray examination. Other procedures including splenoportography, wedged hepatic vein catheterization, selective celiac arteriography, and measurement of hepatic blood flow all play an important role in assessing portal hypertension, but are of little value in the acutely bleeding patient.

There are several unique features in the management of hemorrhage in the cirrhotic patient. Hepatic encephalopathy with elevated blood ammonia is a frequent complication and early administration of antibiotics, usually oral neomycin, to reduce urease producing bacteria is advisable. Narcotics and sedatives must be avoided, or if absolutely necessary given in reduced dosage. Fresh blood is better than standard bank blood in supplementing possible clotting factor deficiencies.

One or more of the following non-operative procedures are usually employed in an attempt to control variceal bleeding. Each procedure has its advantages and none is entirely satisfactory. Rapid intravenous infusion of vasopressin (Pitressin) reduces portal blood flow and pressure by inducing splanchnic arteriorlar constriction[2, 3]. The effect is transient, less than one hour, and repetitive doses of vasopressin are frequently required. Potential complications and undesirable side effects include arterial occlusion, either coronary or mesenteric, reduced hepatic arterial perfusion and systemic hypertension. Nevertheless, in appropriately selected patients intravenous vasopressin is frequently effective in stopping variceal bleeding and is the favored form of therapy in many clinics. Gastric cooling, not freezing, has also been effective, but is not frequently used. Elaborate equipment, need for constant monitoring, and hazards of gastric intubation are the major drawbacks. Esophageal balloon tamponade for 24 to 48 hours is still considered by many to be the most reliable means of controlling hemorrhage from varices. Expert placement and conscientious supervision are required to avert the too frequent complications of esophageal rupture, asphyxia and aspiration[4]. Esophagitis with severity proportional to duration of tamponade is an almost constant and hazardous complication.

If variceal bleeding stops, the patient should have an elective portacaval shunt at the earliest possible time. This may be within a few days for patients with little or no evidence of hepatic decompensation. For those with jaundice, ascites or encephalopathy surgery is best delayed for several weeks or longer until liver function can be restored to the best possible state.

If variceal hemorrhage cannot be controlled by intravenous vasopressin and balloon tamponade, emergency surgical procedures must be considered. Experienced surgeons wisely elect an immediate portacaval shunt if the patient's hepatic status is reasonably well compensated. An effective shunt stops variceal hemorrhage and virtually eliminates recurrence. Transesophageal ligation of the bleeding varix has also been advocated, but this only offers temporary control. Since a subsequent portacaval anastamosis must be performed the patient is exposed to two major surgical procedures. Varix ligation is not the procedure of choice in good risk patients.

A much more difficult problem arises when a poor risk patient with moderate to severe liver failure continues to bleed. Both emergency surgery and continued non-operative management are associated with excessively high mortality. Therapeutically aggressive physicians still view emergency portacaval shunt as the best hope for survival; others favor varix ligation. Those opposed to operative intervention point to a prohibitive operative mortality, a high incidence of progressive hepatic dysfunction after surgery and frequent incapacitating encephalopathy for survivors. Firm recommendations as to the best form of therapy cannot be made, and the management of variceal hemorrhage in patients with decompensated liver disease remains a most difficult and unsettled problem.

The high mortality from variceal hemorrhage led to consideration of performing a portacaval shunt before the first episode of hemorrhage. Recently, several well controlled studies showed that while a prophylactic portacaval shunt eliminated the risk of hemorrhage



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(Continued from page 352)

it failed to improve the statistics for ultimate survival[5, 6, 7, 8]. The main problem is that only a minority of patients with varices ever experience bleeding. If prophylactic shunts could be limited to only those patients with high risk of bleeding the procedure might prove useful. Unfortunately it is not possible to predict accurately which patient with esophageal varices is most likely to bleed. Another hazard of prophylactic shunting is seen in the small percentage of patients with good liver function in whom progressive hepatic decompensation follows diversion of portal blood flow from the liver. Currently, prophylactic shunts cannot be recommended.

Many unsolved problems remain in the management of portal hypertension and variceal hemorrhage. Much of our current treatment is based on clinical studies lacking the necessary control observations. As such, the reported results on modes of therapy are sometimes difficult to reproduce, and recommendations frequently conflict. Perhaps solution to the problems must await development of better diagnostic and therapeutic measures. On the other hand a greater number of properly controlled clinical studies, like those evaluating prophylactic shunts, could provide better answers with current techniques.

References

1. McCray, R. S., Martin, F., Amir-Ahmadi, Sheahan, D. G., Zamcheck, N. Erroneous diagnosis of hemorrhage from esophageal varices. *Amer. J. Digest, Dis.* 14: 755, 1969.
2. Shaldon, S., Sherlock, S. The use of vasopressin (Pitressin) in the control of bleeding from esophageal varices. *Lancet* 2: 222, 1960.
3. Conn, H. W., Simpon, J. A. A rational program for the diagnosis and treatment of bleeding esophageal varices. *Med. Clin. No. Amer.* 52: 1457, Nov. 1968.
4. Conn, H. O. Hazards attending use of esophageal tamponade. *New England J. Med.* 259: 701, 1958.
5. Conn, H. O., Lindenmuth, W. W. Prophylactic portacaval anastomosis in cirrhotic patients with esophageal varices. *New England J. Med.* 279: 725, 1968.
6. Resnick, R. H., Chalmers, T. C., Ishihara, A. M., Garceau, A. J., Callow, A. D., Schimmel, E. M., O'Hara, E.T., and The Boston Inter-Hospital Liver Group. A controlled study of the prophylactic portacaval shunt. *Ann. Int. Med.* 70: 675, 1969.
7. Jacksn, F. C., Perrin, E. B., Smith, A. G., Dagradi, A. E., Nadal, H. M. A clinical investigation of a portacaval shunt. *Amer. J. Surg.* 115: 22, 1968.
8. Conn, H. O. Editorial: Prophylactic portacaval shunts *Ann. Int. Med.* 70: 859, 1969.

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"Tell me more, Watson, and be quick about it!"

(Watson withdraws a folded paper from inside his greatcoat, and reads aloud from it):

"The key to the whole cypher is SYNTHROID (sodium levothyroxine)"...

"Shhh! Watson, not so loud! You'll alert our quarry."

(Watson continues): "A single entity that serves two functions."

"A master stroke, Watson."

"Follow along, Holmes. In the neighborhood of 95% of the circulating thyroid hormone is levothyroxine—T_4 as you call it. T_4 is bound to thyroxine-binding proteins in the serum. It becomes available only gradually to tissue cells—as free thyroxine."

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"But how does 'free' thyroxine fit into the picture?"

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"Magnificent, Watson! So protein-bound thyroxine is the major form of circulating thyroid hormone, and it is released as 'free' thyroxine. And that's why SYNTHROID is able to simulate the normal process so artfully. Q.E.D."

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VOLUME 68 June 1970 No. 6

Epidermoid Carcinoma in Chronic Osteomyelitis: A Diagnostic Problem†

EUGENE SLUSHER, M.D.*
Lexington, Kentucky

Any case of chronic draining osteomyelitis entering your office is suspect of harboring an epidermoid carcinoma in the sinus tract. This is especially true if there has been a change in symptoms.

THE purpose of this paper is to present five cases of chronic osteomyelitis with associated sinus tracts that were thought clinically to have developed epidermoid carcinoma and were treated as such. One of the cases, however, showed only pseudoepithelial hyperplasia. These cases will indicate how difficult it is in some patients to differentiate pseudoepitheliomatous hyperplasia from epidermoid carcinoma. Pseudoepitheliomatous hyperplasia very closely simulates epidermoid carcinoma both clinically and pathologically.

Epidermoid carcinoma arising in sinus tracts is said to be rare[7, 8, 9]. McAnally and Dockerty at the Mayo Clinic analyzed 4,000 cases of osteomyelitis and found carcinomatous change in only 0.23 per cent of the cases[10].

The most frequently reported site of origin is the tibia. However, it has been reported to occur in the femur, calcaneus, metatarsals, skull and metacarpals[1]. Other areas have been reported but are much less frequent. The original lesion usually is an open fracture. Epidermoid carcinoma has been reported in hematogenous osteomyelitis[1] and in tuberculous osteomyelitis[2]. One of our cases developed epidermoid carcinoma in blastomycosis. Fibrosarcoma has also been reported to occur in chronic draining osteomyelitis[6]. This is a much rarer lesion than squamous cell carcinoma arising in the osteomyelitis sinus tracts[6, 4].

The onset of neoplastic change has occurred as early as one and a half years[5] and as long as 64 years after the onset of the infection; the average is said to be about 30 years[9].

The symptoms and signs associated with epidermoid carcinoma are increased pain, bleeding, the presence of a mass and an increased discharge. These usually are considered part of the infectious process and an unnecessary delay in excision of the tumor results. Roentgenograms of the area may show bony involvement by tumor.

Biopsy of the lesion can be very misleading unless multiple sites are biopsied both on the surface and deep in the ulcer and sinus tract[5]. Bony erosion on the x-ray may suggest carcinomatous change. In some cases, excision of the lesion is necessary to prove malignant change as is shown in case IV.

Epidermoid carcinoma arising in sinus

†*Supported in part by the American Cancer Society.*
**Department of radiology, University of Kentucky Medical Center and the Lexington Clinic, Lexington*

tracts of chronic osteomyelitis usually does not metastasize but has been found to spread locally. Spread to regional nodes, to liver, lungs, kidney and distant nodes has also been noted[10, 11, 12, 13]. Invasion of bone with involvement of cortex as well as the medullary canal occurs frequently[1].

The condition of pseudoepitheliomatous hyperplasia was recognized by Whits and Weidman in 1927 who pointed out that it is sometimes impossible to distinguish histologically between squamous cell carcinoma and benign hyperplasia. They made a plea for caution in interpretation of histological signs of early malignancy at the edge of a chronic ulcer, and advised against a confident diagnosis of malignancy unless invasion had reached the level of the sweat glands or had penetrated beyond them. Cruiskshank, McConnell and Miller[2] found the diagnosis of pseudoepitheliomatous hyperplasia led only to unfortunate delay in treatment.

The epidermoid carcinoma in osteomyelitis sinus tracts may have a similar etiology as epidermoid carcinoma arising in burn scars[14]; chronic leg ulcers[3]; bed sores[2]; and varicose ulcers[2].



FIG. 1a Case 1. Photograph of sagittal section of amputated femur showing large tumor mass of lower thigh with invasion of the femur.



FIG. 1b Case 1. Radiograph of distal femur gross showing bony destruction with associated pathological fracture.

The following cases were accumulated at the University of Kentucky from 1963 through 1967.

Case I

This is a 75-year-old white male who presented with a draining sinus and pain in the left thigh for three years which had progressively gotten worse. Treatment had been antibiotics with little or no response. A left A-K amputation was performed. The pathologist reported chronic osteomyelitis with well-differentiated squamous cell carcinoma arising in the draining sinus and destroying the distal femur. No metastatic lesions were reported clinically or in the pathology specimen. (Fig. 1a, 1b).

Case II

This is a 51-year-old white male who was admitted to the surgical service with a history of amputation of the right leg several years previously because of chronic osteomyelitis that had been present since age 13. Chronic osteomyelitis had been present in his left shoulder since age 13 also but had shown little or no change until 16 months prior to this admission when it began to enlarge, showed increased drainage, and produced shooting

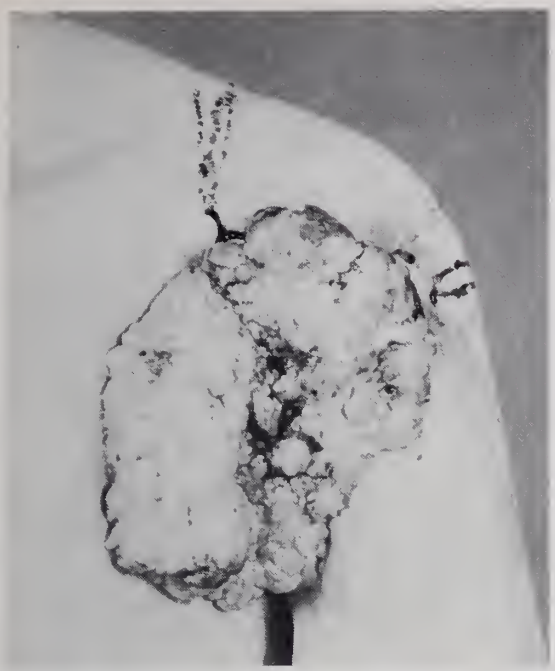


FIG. 2 Case II. Photograph of left shoulder showing large fungating epidermoid tumor that arose in sinus tract of chronic osteomyelitis. Blastomycosis was found to have produced the osteomyelitis.

pains through the shoulder. Biopsy and smear showed blastomycosis and pseudoepitheliomatous hypertrophy and hyperplasia. The drainage improved on treatment with Amphoteracin B but growth of the ulcer increased rapidly and the patient was readmitted with a presumptive diagnosis of squamous carcinoma. Repeat biopsy showed grade I squamous carcinoma. The patient underwent left forequarter amputation. The pathologist found superficially infiltrating squamous cell carcinoma in the sinus tract. No positive nodes were found. (Fig. 2).

Case III

This is a 50-year-old male with a chronic osteomyelitis of the right mid-tibia since the age of five years. The osteomyelitis had caused little difficulty and required no treatment until about one year prior to admission when the sinus tract began to drain pus and bone chips and the area in and around the sinus tract began to enlarge. Biopsy of the sinus tract was reported as squamous cell carcinoma. Below-the-knee amputation was performed with the pathologist finding squamous carcinoma in the sinus tract and adjacent bone cortex and marrow cavity. Groin dissection revealed no nodes with metastatic cancer. (Fig. 3).

Case IV

This 57-year-old white male had developed hematogenous osteomyelitis of the left calcaneus at age 10 years with associated chronic drainage. Three to four weeks prior to admission the lesion was noted to have enlarged, have shown increased drainage and had become painful. Biopsy was reported as extreme pseudoepitheliomatous hyperplasia. Below-the-knee amputation was performed and a definite diagnosis of squamous cell carcinoma arising in the sinus tract was made. (Fig. 4a, b, c).

Case V

This was the first admission for this 42-year-old white female with a history of chronic



FIG. 3 Case III. Roentgenogram of the leg made prior to amputation shows destructive bony changes of osteomyelitis and tumor in the cortex as well as medullary involvement of tibia.



FIG. 4a Case IV. Photograph of foot showing chronic sinus with fungating tumor.

osteomyelitis following an open fracture of the left tibia at 12 years of age. Previous attempts at saucerization failed and the patient was admitted for and had a B. K. amputation. The pathology specimen showed chronic osteomyelitis and pseudoepitheliomatous hyperplasia. No carcinomatous changes were seen. (Fig. 5a, b, c).

Discussion

The five cases presented here differ very little from those reported in the literature except for the case of epidermoid carcinoma arising in a sinus tract of chronic osteomyelitis of blastomycosis. All cases were suspected of having epidermoid carcinoma, however, one showed only pseudoepitheliomatous hyperplasia in the excised specimen.

Distant spread was suspected in only one case (case III) however, groin dissection showed only inflammatory change in the excised nodes. Local spread beyond the sinus tract was present in all four cases of epidermoid carcinoma.

All of the patients in this series had a change in the signs and symptoms related to their osteomyelitis, whether they had epidermoid carcinoma or pseudoepitheliomatous hyperplasia. They all complained of increasing pain, increasing discharge, enlarging mass and failure to respond to medical treatment. These changes should make one suspect the development of epidermoid carcinoma.

X-ray evidence of bony destruction is not distinctive for epidermoid carcinoma since it can occur in both osteomyelitis and pseudoepitheliomatous hyperplasia. The most important diagnostic procedure is a biopsy[5]. This should be taken from the superficial lesion, deep in the sinus tract, and in multiple sites. If the biopsy is negative, yet clinically carcinoma is suspected, I would suggest repeating the biopsy.

Treatment is surgical amputation in both epidermoid carcinoma and pseudoepitheliomatous hyperplasia[1]. Johnson and Kempson justify amputation in pseudoepitheliomatous hyperplasia on the grounds that "epidermoid carcinoma will be missed because the tumor is so well differentiated that a definite histological diagnosis of carcinoma cannot be



FIG. 4b Case IV. Photograph of sagittal section through amputated foot and lower leg. Tumor invasion of the calcaneus is obvious.



FIG. 4c Case IV. Radiograph of the foot prior to amputation showing chronic osteomyelitis and bony destruction of calcaneus secondary to tumor invasion.



FIG. 5a Case V. Photograph of amputated leg, anterior view. Fungating ulcerative lesion is seen on anteriomedial aspect of leg.

made." Multiple biopsies may even miss the lesion as in Case IV. Many of the cases with extensive osseous destruction secondary to pseudoepitheliomatous hyperplasia will have a non-functioning limb and thus amputation is the treatment of choice. Regional lymph nodes should be biopsied at the time of amputation[1]. Follow-up on all four cases to date shows no evidence of metastatic carcinoma or death from the epidermoid carcinoma.



FIG. 5b Case V. Photograph of sagittal section of amputated leg showing that there is destruction of lower tibia.

Summary

Four cases of epidermoid carcinoma arising in sinus tract of chronic osteomyelitis have been reviewed and one case of pseudoepitheliomatous hyperplasia was presented. The problem of determining if a patient has only atypical pseudoepitheliomatous hyperplasia or epidermoid carcinoma is discussed. One case of epidermoid carcinoma occurring in a sinus tract that had proven blastomycosis was reviewed. The typical clinical signs and symptoms were enumerated. The most important aid in diagnosis is the biopsy. Treatment should be amputation and regional node investigation in all cases of epidermoid carcinoma and atypical pseudoepitheliomatous hyperplasia.

References

1. Johnson, L. L., and Kempson, R. L.: Epidermoid Carcinoma in Chronic Osteomyelitis: Diagnostic Problem and Management. *J. Bone and Joint Surg*, 47-A:133-144, 1965.
2. Cruickshank, A. H., McConnell, M. E. and Miller, D. G.: Malignancy in Scars, Chronic Ulcers and Sinuses: *J. Clinical Path.*, 16:573-580, 1963.
3. Sborov, A. M.: Tumor Conference, Chronic Leg Ulcer: *Minnesota Medicine*, 419-420, April 1964.

(References continued on page 377)



FIG. 5c Case V. AP and lateral radiograph of leg shows destruction of the distal tibia.

Childhood Psychosis: A Review of the Syndrome

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Childhood psychosis need not be an enigma when it is defined as a group of clinical syndromes which share certain pathognomonic symptoms. When these symptoms are distinguished from non-specific symptoms, differential diagnosis is also clarified.

FOR most physicians, including many psychiatrists, childhood psychosis** is a very puzzling subject. Perhaps our best entree to this enigma is via a concrete incident:

A busy executive assigned his secretary the task of purchasing a Dalmation. The secretary opened her notebook and asked a long series of specific questions: "How big a Dalmation do you want? How old? What price? How soon do you want it?" etc.

After a half hour of such questions, the secretary seemed to have covered every detail. She closed her notebook, started out the door, and said "Okay, I'll have it for you today." But, halfway out the door, she paused and said: "By the way, what in the world *is* a Dalmation?"

This is quite parallel to our present understanding of childhood psychosis. Although we now have a rich body of description of the clinical *syndromes,* we cannot yet be sure of what is (or what are) the underlying *disease entities.* "Disease entity" implies that we at least agree upon a specific etiology, a specific pathology (which may be in psychological terms), a specific natural course of the disease, etc.

As a matter of fact, there is also disagreement as to just which clusters of symptoms are properly to be labeled as psychosis in childhood. Among members of the same staff of a given child psychiatry center, there is reliable agreement; but there are marked discrepancies from one center to another, and from one expert authority to another. Thus we have Kanner's[1] "Early Infantile Autism"; Mahler's[2] "Symbiotic Psychosis"; Rank[3] Putnam[4] and Pavenstedt's[5] "Child with Atypical Development"; Bender's[6] "Childhood Schizophrenia"; Goldfarb's[7] "Childhood Schizophrenia"; Ekstein and Wallerstein's[8] "Borderline Psychotic Child"; Rank and Kaplan's[9] "Pseudoschizophrenic Child"; Bergman and Escalona's[10] "Child with Unusual Sensitivity"; and others.

As we study the actual clinical descriptions underlying these various names and concepts applied to psychotic children, we find both similarities and differences. With our present knowledge, we cannot formulate childhood psychosis as a single distinct disease entity, but rather as a heterogeneous group of related, overlapping clinical syndromes (perhaps seven or eight in number). The main substance of this paper will be a listing of the *common* parts of these various syndromes; but first, a brief note on the reason for such diversity and lack of agreement.

Although some of the problem is due to partial differences among the patient population being studied at the various child psychiatry centers, the most basic reason for the conflicting opinions is the fact that the concept "psychosis" grew out of adult psychiatry and only belatedly has been applied to children.

The concept "psychosis" had its origin in the clinical description of certain kinds of adult patients who demonstrated:

1. A markedly distorted relationship with reality (withdrawn from the environment; often showing delusions and hallucinations.)

2. A chaotic, disorganized quality in behavior and thinking.

3. Relatively severe disruption of not just

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**The age-range referred to for "childhood psychosis" is: with onset at any time prior to 11 years of age. Actually, in the majority of cases the onset is observable prior to five years of age.

one aspect, but most or all aspects of adaptation, including social, intellectual, occupational, sexual, etc.

4. Inability to be responsible for oneself; poor judgment; socially inappropriate behavior.

When we attempt to apply these criteria to children, we have to look for quite *different symptoms,* because the child's personality is in an earlier stage of development, is constantly growing and changing, and is still incomplete in many ways. As a result, some behavior that would be considered psychotic in an adult is *not* psychotic in children at a certain age, and *not even abnormal* in children at a still younger age (e.g. a marked egocentricity of interests and attention, or refusal to communicate in response to certain situations; accusing others of being " . . . all against me", spoken in the heat of battle.)

Furthermore, it is much harder for the physician to get verbal expression or confirmation of what the child is experiencing, than is the case with psychotic adults. This makes it much harder to discern such clear-cut, flagrant symptoms of psychosis as delusions and hallucinations.

So much for our very condensed survey of the reasons for the welter of conflicting viewpoints on childhood psychosis. We can resolve this confusing situation by pulling together the *common* parts of the clinical descriptions from all the various child psychiatry centers, and picking out those symptoms which (in the author's opinion) should be considered pathognomonic for childhood psychosis. These pathognomonic symptoms (to be called "cardinal symptoms") are both necessary and sufficient for the diagnosis.

The critical point of diagnosis is to distinguish these cardinal symptoms from a second group of symptoms (to be called "non-specific") which are frequently present in childhood psychosis, but are neither necessary nor sufficient for the diagnosis. These non-specific symptoms do occur in other conditions and are therefore *not sufficient* for the diagnosis; and one does find cases of childhood psychosis without these symptoms, so they are *not necessary* for the diagnosis. However, when present they can be the most prominent, spectacular part of the presenting clinical picture of childhood psychosis, a situation which causes much of the confusion about differential diagnosis.

Cardinal Symptoms

I. Characteristic Severe Impairment of Contact With the Environment, Especially the Social Environment

Most basically, psychotic children do not relate to persons *as persons,* as manifested in the following ways:

1. A curious deficiency of eye contact. The child seems to focus his gaze right through or beyond the examiner, giving rise to the feeling: "He looks at me as if I'm not there."

2. Unresponsiveness to spoken words, sometimes giving the impression of deafness. These children are much more consistently oblivious to sounds with personal and social meaning than to inanimate sounds.

3. Lack of distinguishing people from inanimate objects. One child would walk right over (and *step on*) sunbathers lying on a beach. Another child, after dismembering a special doll built to be taken apart, then tried to unscrew the *psychiatrist's* arm and pry off *his* head.

4. Relating only to a *part* of the examiner (especially to the hand) rather than to the whole person.

Psychotic children's contact with the inanimate environment does not show such consistent or characteristic impairment. In those cases where the child does appear well "tuned in" to the inanimate environment, there is a marked *discrepancy* between his relationship with the inanimate environment and his (much poorer) relationship with the social environment.

II. Characteristic Impairment of Effect and Its Expression

Most basically, this is an *incongruity* of effect, e.g. an apparent smile which conveys neither mirth nor warmth, "sends" no feeling. At other times, the child may seem to be having a strong emotion, but the observer cannot "read" the feeling.

Effect may be flat, have a very narrow range. Also, the child may show sudden baffling changes in mood, with no apparent cause.

III. Impairment of Speech, Especially its Use for Social Communication

Although speech is absent in some psy-

chotic children, it is present in others. If speech is present, there is a *discrepancy* between possession of a vocabulary and ability to use it for social communication. It is this impairment of the *use* of speech for social communication which is pathognomonic.

Examples of the non-communicative use of speech include:

1. Repetitious reciting of TV commercials and other stereotyped "spiels."
2. Echolalia, neologisms, having one's own private language, or other highly idiosyncratic speech.
3. Sing-song or monotonous speech which fails to communicate appropriate effect by intonation, pitch, melody, emphasis, or rhythm; also, timbre of voice is peculiar (hollow, squawking, or shrill.)

IV. Characteristic Impairment of Sense of Personal Identity

It would be justified to replace the word "impairment" here with the word "absence": the psychotic child lacks a unified sense of self as the subject of his feelings, sensations, pain or pleasure, or as the subject of his actions. E.G., one child said: "There's a baby grasshopper," and then looked around the room in a searching manner, saying: "Somebody said 'There's a baby grasshopper' " (said with genuine perplexity.) The observer felt the child was obviously unable to experience himself as the subject of his own voice.

This "dysidentity" may also show up in the child's reversal of pronouns; most characteristically, he does not refer to himself in the first person ("I" or "me"), but instead uses "you" or "he" in a context tantamount to referring to himself.

Some psychotic children begin to form some unified identity as a non-human object, especially some machine, such as an electric fan, automobile or vacuum cleaner. The child will make noises like a vacuum cleaner, talk to "other" vacuum cleaners, etc. This phenomenon gives an entirely different feeling to the observer from that of a child merely *pretending* to be a vacuum cleaner; for the psychotic child, being the machine is his *literal* (and entire) sense of self.

V. Unevenness of Development; Disorganization and Lack of Intergration of Personality

Many psychotic children show "islands" of precocious functioning in the midst of grossly primitive, infantile behavior in other areas, e.g. the eight-year-old who could recite the proper scientific names of all the bird species in North America, but could not take a bath or feed himself.

Most psychotic children constantly give off a feeling of chaos and great disorganization, a sense of panicky confusion.

This lack of personality integration also shows up in the psychotic child's inability to *play*. His fiddling with various objects, and his use of fantasy, somehow lack qualities we normally sense in children's play. The difference seems to be due to a combination of (1) the sense of chaos, (2) an empty, vacuous quality, (3) a desperate, driven quality and (4) the absense of any sense of enjoyment.

Non-Specific Symptoms

I. Inability to Grasp Basic Categories of Thought

Some psychotic children show endless preoccupation with their puzzlement over such concepts as time, space, cause-and-effect, matter and texture, . . . basic modes of thinking which normally take place "autoatically", without even calling for any conscious attention. For example, some psychotic children can not intuitively grasp that an object has an "other" side or an edge, as if his understanding of the spatial and material properties of physical objects has not progressed beyond that of the infant of five to eight months of age.

II. Various Disturbances of Motility

Some psychotic children are hyperactive, some are not. A more characteristic disturbance of motility is preoccupation with a very narrow range of actions (e.g. constantly shaking a certain string or rope, walking in a circle, flapping his hands close to his head, or repetitively tapping *every* object in a caricature of a "karate chop.") These motility patterns are stereotyped, usually look bizarre, and seem to be unrelated to anything the observer can see in the "real" external environment.

Another motility disturbance shown by some psychotic children is rhythmic primitive movements such as rocking, head-banging, "whirling", or simply jumping up and down repetitively in the same place. It is this

"whirling", in which the child repeatedly spins around (as is done when preparing to "Pin The Tail On The Donkey") which Lauretta Bender[6] singled out as being of such great diagnostic significance; it turns out, however, that this "whirling" phenomenon occurs in only about 25 per cent of psychotic children.

III. **Impaired Control of Impulses**

Many psychotic children are unable to maintain even minimal social conformity when not under the constant direct guidance of an adult. The adult charged with the care of such an impulsive child has to resort to something very close to "man-to-man" guarding or something like a "full-court press" in order to prevent sudden harmful misbehavior. (The analogy to basketball defense is only a slight exaggeration.)

When such impulsivity is combined with hyperactivity, it may constitute *the* presenting problem, *the* reason for exclusion from school and referral to the physician. Such a situation presents a problem in differential diagnosis, for hyperactivity and impulsivity can also be seen in the "minimal brain damage" syndrome, as well as in the antisocial child and in certain neurotic children with acute anxiety. It is a direct and simple matter to rule out (or rule in) childhood psychosis on the basis of the presence or absence of the five cardinal symptoms.

IV. **Impairment of Social Skills**

When the psychotic child shows some improvement, so that he begins to seek some social contact, he seeks such contact by running full-speed and crashing into the adult's leg, stepping on his foot, leaning very awkwardly against him, etc. The psychotic child also shows excessive reliance upon *indirect* ways of relating, such as tossing a ball or rolling a marble toward the adult. Such a child is also unable to "read" various social cues, e.g. sensing whether another person is kidding or serious.

V. **Lack of Age-Appropriate Defenses by Which to Handle Anxiety**

Under this rubric we can include the following behavioral symptoms:

1. Marked immaturity of mannerisms and behavior.

2. Excessive anxiety, resembling that of an anxiety neurosis.

3. Neurotic defenses, especially phobic and obsessive-compulsive defenses.

Thus some cases of childhood psychosis require differential diagnosis (respectively) from immature personality disorders, from anxiety neuroses or from phobic or obsessive-compulsive neuroses. In all cases the differential diagnosis can be made on the basis of the presence or absence of the five cardinal symptoms.

VI. **Obsessive Insistence on Sameness**

Some psychotic children have extremely severe panic or temper tantrums in response to any change in either the arrangement in *space* of various familiar objects, or in the sequence in *time* of daily routines.

This symptom is especially consistently present in that sub-group of psychotic children designated by Kanner[1] as "Early Infantile Autism." It has traditionally been regarded as pathognomonic for "Early Infantile Autism"; however, it actually is *not sufficient* for the diagnosis (of either Early Infantile Autism or of any other kind of childhood psychosis) because obsessive insistence on sameness does occur in varying degrees in other conditions, especially in some cases of mental retardation and in some cases of the syndrome of "minimal brain damage."

Perhaps this symptom is best viewed as a rote adaptation to the *general* problem of having very limited adaptive skills, and yet having to cope with complexity and change in the environment: abolishing *all* change is apparently an attempt to reduce drastically any demands for flexible adaptation.

Further Comments on Differential Diagnosis

As stated earlier, the difficulties concerning the differential diagnosis of childhood psychosis can be resolved by discriminating cardinal symptoms from non-specific symptoms. In every specific case, childhood psychosis can be ruled in or ruled out on the basis of the presence of absence of the five cardinal symptoms. In the course of our listing of the non-specific symptoms, we applied this touchstone to two of the clinical situations in which one has to rule out childhood psychosis:

I. Hyperactive-impulsive behavior

II. An apparent neurosis, especially of the obsessive-compulsive, phobic or anxiety type

The differential diagnosis of childhood psychosis includes three additional items:

III. Mental retardation

IV. Other conditions with delayed or absent speech

V. Other conditions in which the child deviates from consensus (i.e. behaves in an odd or "different" way.)

The problem of differentiating mental retardation from childhood psychosis occurs because both conditions are manifested by disturbances of personality *development,* development which, in the very young child, has *not yet occurred.* In addition to applying our touchstone of the presence or absence of the five cardinal symptoms of childhood psychosis, the following practical points are helpful:

1. Although many retardates show a kind of stereotyped rigidity and monotony in their behavior and in their topics of conversation, it is not on such a *private, unshared* basis as in psychotic children.

The examiner can much more easily "tune-in" to and understand their narrow little world.

2. The retardate does not show such *unevenness* of development; rather, he usually shows a more uniform, even, across-the-board retardation in most areas.

3. The retardate does not show the marked chaos and disorganization that the psychotic child does.

4. The retardate's topics of conversation are usually limited to simple, concrete subjects which are related to the immediate environment. This stands in contrast to the psychotic, whose topics and interests usually seem quite complex and abstract, as well as unrelated to the immediate environment.

We can only comment briefly about the last two areas of differential diagnosis (that of delayed or absent speech and that of deviation-from-consensus.)

Actually, the most frequent cause of delayed or absent speech is mental retardation. Other causes, besides childhood psychosis, are:

1. Minimal brain damage

2. Nerve deafness (Only *nerve* deafness, not conduction deafness, is a significant cause of delayed speech.)

3. Aphasia

4. "Developmental aphasia"

5. Severely neglected "uncivilized" children. usually found in conditions of pervasive *social* pathology and poverty. These children resemble the sociopathic group more than any other diagnostic group.

6. Elective mutism: This is best classified as a type of neurotic character, in which the child is *motivated* to *withhold* speech, usually in the manner of a stubborn, oppositional two-year-old.

The other conditions in which the child deviates from consensus, aside from childhood psychosis, are:

1. Neuroses (especially phobic and obsessive-compulsive neuroses.) It is the intensity of the neurotic child's involvement in his rituals and avoidances (which appears so out-of-keeping with our common-sense view of the unimportance of such things) which gives the appearance of marked oddness.

2. Personality traits such as shyness, active fantasy life and noticeable daydreaming, . . . which may be found in normal or neurotic children.

3. Primitive behavior in severely neglected "uncivilized" quasi-sociopathic children (e.g. eating feces or parts of a dead animal. In these children, such shockingly indiscriminate oral incorporation amounts to a form of *pica.*)

4. Tics, especially *vocal* tics (e.g. in the Tic of Gilles de la Tourette.)

Again, throughout this entire variety of conditions which can resemble childhood psychosis, the differential diagnosis can always be made on the basis of the presence or absence of the five cardinal symptoms of childhood psychosis.

Summary

The problem of multiple conflicting definitions of childhood psychosis was discussed. As a solution to this problem, it was proposed that we define childhood psychosis as a heterogeneous group of related clinical syndromes, all of which share five pathognomonic symptoms in common.

The key to the knotty problems of differential diagnosis of childhood psychosis lies in distinguishing these pathognomonic (or "cardinal") symptoms from the non-specific symptoms which, when present, may dominate the presenting clinical picture of childhood psychosis. This key principle was then briefly applied to the five types of condition in which the question of differential diagnosis from childhood psychosis usually arises.

(References on page 377)

Acute Promyelocytic Leukemia

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Promyelocytic leukemia, the gravest clinical form of leukemia, is rarely reported. This paper concerns a case recently observed in this area. Emphasis is placed upon the importance of the coagulopathy and upon the probable cause of sparcity in reports.

THIS paper deals with a rarely reported type of leukemia characterized by a very rapid clinical demise, a marked hemorrhagic tendency due to disorders of fibrinogen metabolism which are not observed in other acute leukemias, and a proliferation of atypical promyelocytes in the bone marrow. Although an autopsy was not performed, the clinical picture, laboratory results and bone marrow study in this case supported conclusive evidence to substantiate the diagnosis of acute promyelocytic leukemia. Even though this type of leukemia, first described by European investigators, has been recognized as a definite nosologic entity, only about 60 cases have been recorded in medical literature[1, 2, 5].

Case Report

This 49-year-old man was admitted on January 14, 1970 with a three day history of "smothering, weakness, and a lump in the left side of the neck". The examining physician also noted ecchymotic areas of the skin, forehead and left side of the neck. The patient also noticed that he would "bruise easily" during the three days before admission. Four weeks before admission he was treated with Ampicillin for a cellulitis in his right forearm and two weeks before admission had complained of some low back pain which was treated symptomatically with analgesics.

Physical—showed an anemic appearing 49-year-old man complaining of shortness of breath. Blood pressure 112/70, pulse 130, respirations 26 and temperature 98. The conjunctivae were pale and the skin showed obvious ecchymosis of the neck and a tender mass along the left border of the neck. There were also small ecchymotic areas on the forehead, right forearm and both legs. The lung fields were clear and there was a sinus tachycardia with a grade II of VI systolic murmur heard along the left cardiac border. The abdomen was soft with some minimal tenderness with deep palpation over the left iliac area of the abdomen. Liver and spleen were not palpable.

Laboratory—the chest x-ray showed mild emphysematous changes in the lungs and the EKG showed a sinus tachycardia with nonspecific changes. On admission the stool was negative for blood and the hemoglobin was 6.2, hematocrit 18, WBC 9,150 with a platelet count of 40,800. The peripheral smear

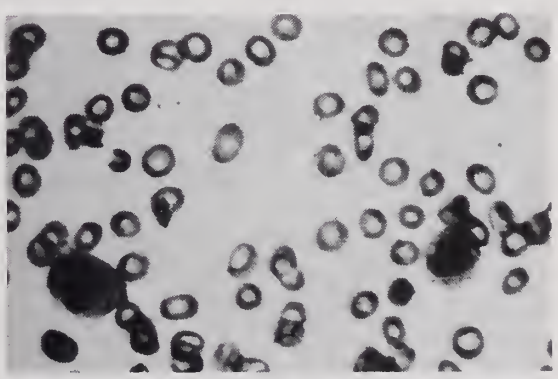


FIG. 1 The peripheral smear shows large and small cells of the myeloid series corresponding to the atypical myelocytes and promyelocytes as the predominant cell type. A satisfactory myeloblast could not be identified but a few mature lymphocytes and neutrophils are present. Note the fairly normal red blood cells (Wright Stain 20X).

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initially showed 15 lymphocytes and 85 cells in the myeloid series (mostly atypical myelocytes and promyelocytes). (Fig. 1.) The Lee and White clotting time was 8 minutes and 30 seconds and a bone marrow examination was done before transfusion was initiated.

Hospital Course—after the initial diagnostic studies were completed he was given two units of fresh blood. On the fourth hospital day he started passing black stool and his hemoglobin dropped to 5.1 and the hematocrit dropped to 13. He was transfused with four more units of blood and referred to a surgeon and an internist. Late on the fourth hospital day he was still bleeding from the GI tract and had a temperature of 102 degrees. His BUN had gone up to 118 mgs. per cent and his white count was 11,400. Bleeding time then was 33 minutes and 45 seconds and the coagulation time was 12 minutes. The initial clot retraction was one hour and 20 minutes and the prothrombin time was reported as 32.3 seconds with a control of 12 seconds. No clot formation was reported after three minutes.

On the fifth hospital day there was a normal partial thromboplastin time and the prothrombin time was prolonged to 21 seconds. The coagulation time was 15 minutes and bleeding time was over 30 minutes. A fibrinogen assay after approximately six units of blood was within normal limits. The fibrinolysin test showed complete lysis in 12 hours. The white count went up to 16,300 and platelet count was 68,000 on the fifth hospital day. An upper GI series showed no abnormality of the upper GI tract but a suggestion of a possible retrogastric mass. The chest film showed a minimal interstitial pneumonitis.

The patient remained confused and partially disoriented and the purpura and ecchymoses became more marked in the upper trunk region. No lymphadenopathy was apparent and he became uremic and went into congestive heart failure. Despite digitalization and supportive treatment he continued his fulminating course and expired in the late evening of the fifth hospital day. The bone marrow examination done on the day of admission reported a hypercellular bone marrow with numerous atypical promyelocytes and myelocytes with extensive replacement of the erythroid elements. (Fig. 2.)

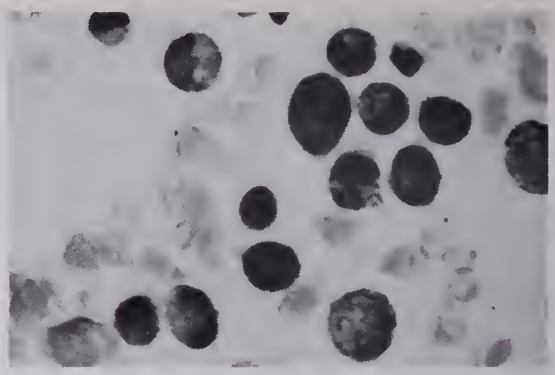


FIG. 2 Shows flooding of the bone marrow by atypical myelocytes and promyelocytes (Wright Stain 20X).

Discussion

A myelo-proliferative disorder of the myeloid series in which the maturation of the cells is apparently arrested at the myelocytic and/or promyelocytic stage should be expected to produce an intermediate, or fruste, form of leukemia. From a strictly hematologic point of view, the clinical course of an intermediate form of leukemia would be expected to be more prolonged than an acute blastic leukemia, but would be less prolonged than the chronic leukemia in which the uncontrolled proliferation of myeloid cells proceeds in the normal fashion to the segmental forms.

The promyelocyte is an intermediate cell between the myeloblast and the mature cells. Thus, from a therapeutic point of view, promyelocytic leukemia should be easier to handle and should be expected to progress to a more chronic form of leukemia. But from previous clinical reports as well as our own patient this was not the case.

Acute promyelocytic leukemia is recognized as one of the gravest forms of leukemia with the shortest survival time. This statement may not be absolute since cases have been described with remissions from eight to 24 months[3]. The fact that all cases reported in medical literature showed strong hemorrhagic diathesis and the majority expired with a clinical picture of exanguinating or cerebral hemorrhage supports the contention that the disturbances of the coagulation process, associated with thrombocytopenia, are primarily responsible for the graveness and acuteness of

this type of leukemia, rather than the effects of the etiologic agent, whatever it may be, on the hematopoetic organs.

Hypofibrinogenemia appears to be the most constant and characteristic hematologic finding, as well as the proliferation of atypical promyelocytes, in this type of leukemia; whereas in other acute leukemias, hyperfibrinogenemia or normal fibrinogen levels is the rule. Thrombocytopenia is a consistent finding of acute leukemias in general, due to the replacement of normal constituents of the bone marrow by leukemic cells.

Many efforts by different authors have been directed at determining the possible cause of hypofibrinogenemia and discrepancies have appeared in the literature between those who report that increased fibrinolysins[2] are characteristic of promyelocytic leukemia and those who find hypofibrinogenemia with no evidence of fibrinolysin activity in the blood[3]. At the same time, repeated liver function tests have consistently failed to demonstrate liver damage to a degree significant enough to incapacitate liver cells in the synthesis of fibrinogen. Thus, a controversy exists in which the mechanism for fibrinogen synthesis appears to be normal and an excess of fibrinolysin activity of the blood has not been clearly established.

Baker and co-workers[6] reported a case with a fibrinogen and factor V deficiency, in which the autopsy demonstrated diffuse intravascular clotting. This would suggest that the bleeding in this case was due to intravascular clotting and defibrination, a fact that has not been supported by other investigators. Neither the cause of the hypofibrinogenemia nor the relationship between the disturbances in the fibrinogen metabolism and the myeloproliferative disorders have been determined at the present time.

Rosenthal[3] reported, as an exceptional event, a promyelocytic leukemia patient with a remission of 18 months, during which time normalization of the bone marrow along with an increase in the fibrinogen level occurred. The event indicates a true relationship between the activity in the bone marrow and the metabolism of the fibrinogen. What is uncontroversial is that hemorrhages due to hypofibrinogenemia and thrombocytopenia account for the graveness and short life span of the patients, rather than the extent of the bone marrow and visceral involvement. In other words, death is usually due to hemorrhages in the vital organs during the first few weeks after initial symptoms, before a visceral response or leukemic infiltration is extensive enough to impair important organic functions. The short life span may explain the lack of response of this process to anti-leukemic drugs.

The case study we have presented shows a similar clinical behavior and similar hematologic findings reported by other authors. The fact that the coagulation studies were performed on the patient after whole blood transfusions and fibrinogen infusions had been administered would explain some of the normal results obtained. The fibrinolysin test showed a complete lysis at 12 hours and this would suggest an increased plasma fibrinolysin activity.

The accuracy of the test is difficult to evaluate since it was a qualitative test performed after the patient had had several blood transfusions. A bone marrow study was done when the patient was initially admitted and was reported on the fifth hospital day. An additional bone marrow puncture was not performed because of the patient's serious condition, and without the benefit of additional studies, the clinical discharge diagnosis was acute myelocytic leukemia.

The rareness of promyelocytic leukemia accounts for the lack of clinical awareness of physicians of its existence. Apparently cases occur that go unrecognized, or are classified under different names. For example, Newman and co-workers'[7] recent report of the late appearance of leukemias in Hodgkin's disease, case #2 clinically and hematologically qualifies to be included in the promyelocytic category of acute leukemia, but they preferred to classify the case as an acute atypical form of leukemia, namely acute myelomonocytic leukemia.

Summary

We have presented a case of acute promyelocytic leukemia of which there are approximately 60 cases reported in medical literature. Promyelocytic leukemia, from a hematologic point of view, behaves clinically

in a very malignant fashion. The clinical picture in our case was similar to that reported by other authors. The coagulation disorder appears to be the salient feature in the short clinical course and not the leukemic process, since visceral involvement is minimal and not of the magnitude necessary to impair the vital functions. The rapid onset of abnormal coagulation accounts for early death, which in turn is probably responsible for the failure of anti-leukemic treatment to produce substantial remissions.

Like this case herein presented, other cases have probably gone unrecognized and have been reported under the diagnosis[4] of acute myelogenous leukemia, which may also account for so few cases being reported in medical literature.

References

1. Paul Didisheim, John S. Trombold and co-workers. Acute Promyelocytic Leukemia with Fibrinogen and Factor V Deficiencies. *Blood,* Vol. 23, No. 6 (June), 1964.

2. Jacobo Ghitis—Acute Promyelocytic Leukemia—*Blood,* Vol. 21, No. 2 (February), 1963.

3. Robert L. Rosenthal—Acute Promyelocytic Leukemia Associated with Hypofibrinogenemia—*Blood,* Vol. 21, No. 4 (April), 1963.

4. Orhan N. Ulitin, Ehrem Ozcan and co-workers. *New Ystanbul Contributions to Clinical Science.* Vol. 8:65-77, 1965.

5. Maxwell M. Wintrobe. *Clinical Hematology,* Lea & Febiger, Philadelphia, Six Edition, 1968.

6. William G. Baker, M. D., Nils V. Bang, M. D., Ralph L. Nachman, M. D., and co-workers. Hypofibrinogemia Hemorrhage in Acute Myelogenous. Leukemia Treated with Heparin. *Annals of Internal Medicine*—Vol. 61:116-123, 1964.

7. Donald R. Newman, M. D., George E. Maldonado, M. D., Edgar G. Harrison Jr., M. D. and co-workers—*Cancer,* Vol. 25:128:134, (January), 1970.



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Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

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Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . 500 mg.

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THE INSURANCE PAGE



It Is Well To View More Than One Side Of A Question

In a recent issue of the Louisville *Courier-Journal,* Joe Creason related a story about former Governor McCreary. During his second term as Governor of Kentucky, in the early part of this century, Governor McCreary was noted for evading the issues and being noncommittal. The story was told that on a train trip, two politicians who accompanied the Governor made a wager that one of them might be able to cause the Governor to make a positive statement about something during the trip. Later in the day as the train passed a large flock of sheep, one of the men pointed out to the Governor the large number of black sheep in the flock and asked the Governor if he had ever seen so many solid black sheep in one place before. The Governor looked for a short while and replied, "They do appear to be black from this side".

The present writer has no more desire than Governor McCreary had in making a positive commitment on certain viewpoints, but would like to see the other side. It is always well to know as many sides of a situation as possible before making any conclusion, and it is doubly important to know the other side if one decides to disagree.

At the Blue Shield Annual Program Conference, October 31, 1969, in San Francisco, labor's viewpoint was presented by John F. Tomayko, director, Department of Insurance, Pension, and Unemployment Benefits, United Steelworkers of America.

Mr. Tomayko stated that it was his belief that Blue Shield should make very drastic or even revolutionary improvements in their organization if they intended to have a realistic approach to the Seventies.

He urged that Blue Shield policy-making and governing boards must truly reflect the needs of the consumers by giving them a controlling interest in the boards. He further stated that he would prefer to assure his members that the participating physicians on the Blue Shield Board, even though they be limited in number, represent the concern of his Union, and that concern is, that the present system of the delivery of health care is not working.

He also recommended that a central power of authority be vested in the national Blue Shield organization, which should be composed mostly of representatives of the consumers, and that their concern should be centered around the fact that health care of the highest quality is a basic human right of every American.

Another important point that he made is that solo practice is out and group practice is in. By group practice he meant a system of comprehensive health care of the highest quality on a prepaid basis. He stated that Blue Shield should be willing to work with such groups. He stated that the evidence is overwhelming in such group's intelligent and economical use of the available health care dollar and he intimated that such groups serve the consumer and not the health profession.

Mr. Tomayko further stated that if Blue Shield is to continue in the Seventies it must begin formulating changes in structure in preparation for a national system of health insurance. He has no doubt that this will become a reality, and asks if Blue Shield will have a role to play. He states that the future of Blue Shield, like the future of labor and the nation, rests with the youth, and the youth of America is demanding change and improvement in that change. Hear their voices and you will succeed.

The writer agrees that the future of all of us rests with the youth of America. Tremendous changes are shaping the future and those who would have some part in shaping these changes, must look at all sides and seek a more realistic approach to the youth of today. Times are changing. LEWIS W. DICKINSON, M.D.

Summer time...monilia time!

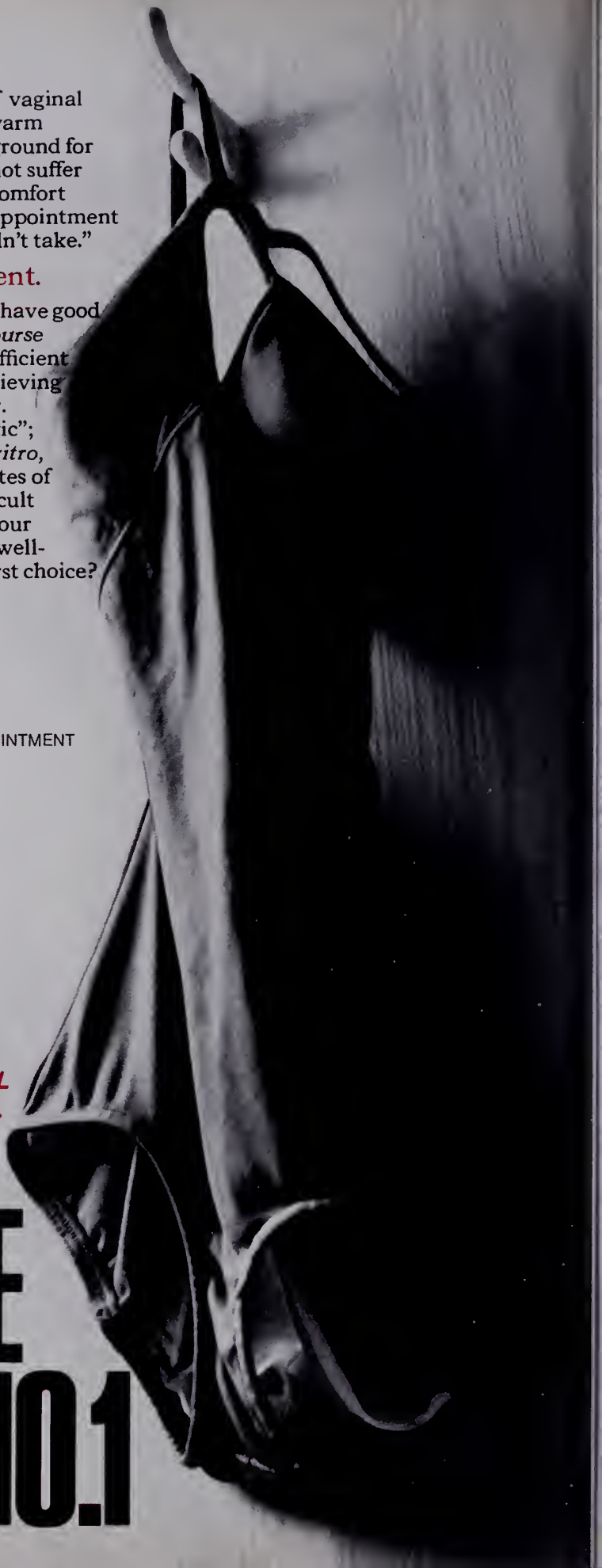
No wonder you see so many more cases of vaginal moniliasis during this season. A damp, warm bathing suit provides a perfect breeding ground for fungal invaders. But your patients need not suffer the pain, the embarrassment and the discomfort of these stubborn infections. Nor the disappointment which comes when they find "the cure didn't take."

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Indications:
Vaginal moniliasis due to Candida albicans and other Candida species.

Contraindications:
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(Continued from page 361)

4. Waugh, W.: Fibrosarcoma Occurring in Chronic Bone Sinus. *J. Bone and Joint Surg.*, 34-B:642-645, November 1952.

5. Engler, H. S., Fernandoz, A., Bliven, F. E. and Moretz, W. H.,: Cancer Arising in Scars of Old Burns and in Chronic Osteomyelitis Ulcers and Draining Sites. *Surgery* Vol. 55:654-663, May 1964.

6. Morris, J. M., Lucas, D. B.: Fibrosarcoma Within a Sinus Tract of Chronic Draining Osteomyelitis. *J. Bone and Joint Surg.*, 46A:853-857, June, 1964.

7. Hobart, M. H. and Miller, D. S.: Osteomyelitis at Cook County Hospital. With an Appraisal of Orr's Method of Treatment. *J.A.M.A.*, 107:1118-1122, 1936.

8. Lovell, W. W., King, R. E. and Alldredge, Rufus: Carcinoma in Skin, Sinuses and Bone Following Chronic Osteomyelitis. *Southern Med. J.*, 50:266-271, 1957.

9. Marks, K. L. and Turner, W. L.: Carcinoma Occurring in the Sinuses of Chronic Osteomyelitis. *British J. Surg.*, 38:206-209, 1950.

10. McAnally, A. K. and Dockerty, M. B.: Carcinoma Developing in Chronic Draining Cutaneous Sinuses and Fistulas. *Surg., Gynec., and Obstet.*, 88:87-96, 1949.

11. Bereston, E. S. and Ney, Charles: Squamous Cell Carcinoma Arising in a Sinus Tract with Metastasis. *Arch. Surg.*, 43:257-268, 1941.

(Continued from page 366)

References

1. Kanner, L.: Problems of Nosology and Psychodynamics of Early Infantile Autism. *Am J Orthopsychiat*, 19: 416-426, 1949.

2. Mahler, M.: On Child Psychosis and Schizophrenia: Autistic and Symbiotic Infantile Psychoses. *The Psychoanalytic Study of the Child*, 7: 286-305. New York: International Universities Press, 1952.

3. Rank, B.: Adaptation of the Psychoanalytic Techinque for the Treatment of Young Childern With Atypical Development. *Am J Orthopsychiat*, 19: 130-139, 1949.

4. Putnam, M.: Some Observations on Psychosis In Early Childhood. In: *Emotional Problems of Early Childhood*, ed. G. Caplan. New York: Basic Books, pp. 519-523, 1955.

5. Pavenstedt, E. & Anderson, 1.: Complementary Treatment of Mother and Child with Atypical Development. *Am J Orthopsychiat*, 22: 607-641, 1952.

6. Bender, L.: The Brain and Child Behavior. *Arch Gen Psychiat*, 4: 531-547, 1961.

7. Goldfarb, W.: An Investigation of Childhood Schizophrenia *Arch Gen Psychiat*, 11: 620-634, 1964.

8. Wallerstein. J. & Ekstein. R.: The Psychology and Psychotherapy of Borderline Psychotic Children, *The Psychoanalytic Study of the Child*, 9: 344-369. New York: International Universities Press, 1954.

9. Rank, B. & Kaplan, S.: A Case of Pseudoschizophrenia in a Child. *Am J Orthopsychiat*, 21: 155-181, 1951.

10. Bergman, P. & Escalona, S.: Unusual Sensitivities in Very Young Children. *The Psychoanalytic Study of the Child*, 3/4: 333-352. New York: International Universities Press, 1949.

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22-24 Annual Meeting, Kentucky Medical Association, Convention Center, Louisville

IN SURROUNDING STATES

JUNE

21-25 Annual Meeting, American Medical Association, Chicago, Ill.

AUGUST

23-28 Annual Meeting, Flying Physicians Association, Bayshore Inn, Vancouver, British Columbia

SEPTEMBER

10-12 Annual Meeting, American Association of Obstetricians and Gynecologists, Hot Springs, Va.

25-Oct. 1 Annual Meeting, American Academy of General Practice, San Francisco, Calif.

OCTOBER

4 Council on Environmental and Public Health, Roosevelt Hotel, New Orleans, La.

5 Annual Meeting, American Academy of Ophthalmology and Otolaryngology, Dunes Hotel, Las Vegas, Nev.

12-16 Clinical Congress of American College of Surgeons, the Conrad Hilton Hotel, Chicago, Ill.

NOVEMBER

6-7 Annual Meeting, Congress of County Medical Societies, Netherland Hilton Hotel, Cincinnati, Ohio

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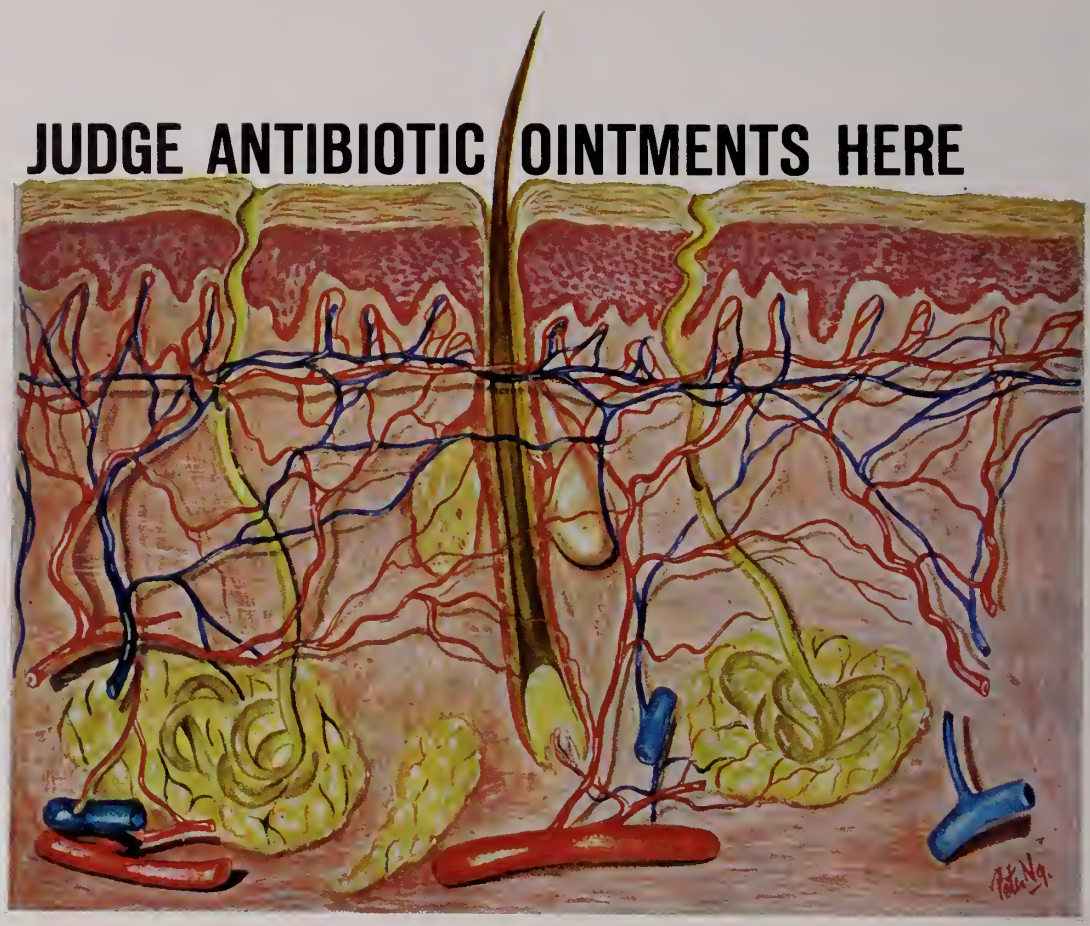
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SPECIAL ARTICLES

Special Report on Proposed Dues Increase

KMA Ad Hoc Committee on Finance

HENRY B. ASMAN, M.D., LOUISVILLE, CHAIRMAN

1. The dues for Active members of the Association shall be $130 per year, effective January 1, 1971—with the exception that

2. The dues for new members entering practice for the first time shall be $80 per year for the first three full years of practice.

AT the direction of the House of Delegates, the Executive Committee of the Board of Trustees appointed an Ad Hoc Committee on Finance to study the present financial structure and the projected financal requirments of the Association, and to make recommendations for such changes in the dues structure that will enable it to carry on its work in an effective and efficient manner.

The members of the Committee were: George Brockman, M. D., Greenville, delegate to the AMA, past-president and chairman of the Building Committee responsible for our present Headquarters Building; Lee C. Hess, M. D., Florence, trustee of the 8th District and past chairman of the Board; Keith P. Smith, M. D., Corbin, treasurer of the Association and past chairman of the Board; Ballard W. Cassady, M. D., Pikeville, trustee of the 14th District and chairman of the Budget Committee, and Henry B. Asman, M. D., Louisville, immediate past-president and former secretary of the Association.

The Committee met on February 7, 1970, and submitted its report to the Executive Committee on March 19, and to the Board of Trustees on April 8. The report was adopted by the Board with minor changes.

Because of the importance of this matter to all of the members, and the impact of its adoption upon the future of the Association, the Board directed that the individual Trustees, in cooperation with this Committee, give wide publicity to the findings and recommendations of the committee prior to the meeting of the House of Delegates in September. This article has been prepared, therefore, so that all members, and especially all delegates, may be knowledgeable when the matter is presented for discussion next fall. The individual Trustees and/or members of the committee will be pleased to appear at any District meeting to discuss the matter.

Methods

In pursuing the charge assigned to the Committee it was judged to be reasonable to review in detail the activities and finances of the Association during the past six years, since the last major dues increase became effective on January 1, 1964, and to base our attempts to project future financial requirements on these findings.

In addition, we studied the current budget and the financial statement for the first six months of this fiscal year. A survey of nine state associations of comparable size and/or geographical proximity enabled us to relate our position and activity to our sister organizations.

We can view with pride the increased growth in stature and in numbers, as well as the many accomplishments of the Association during this space of years. These things didn't just happen, however, but are the result of greater awareness of our responsibilities, and the diligence and dedication with which our members and staff have pursued our purpose—to serve the physician, the profession and the public.

In this fast-changing world, an era of exploding scientific knowledge, challenges to the medical profession from all sides, and scrutiny by the consumer, one does not need a crystal ball to recognize that our activities and responsibilities must continue to expand if we are to remain a vibrant, progressive organization attuned to the times. An inventory of the resources available to meet these challenges reveals an abundance of manpower—talented, knowledgeable, dedicated physicians and staff ready and anxious to move ahead—but a financial structure

that has not kept pace with the present, let alone the demands of the future.

The last major increase in dues was in January 1964. In the interval since then only a $5 increase has been voted, and that was earmarked for the specific purpose of augmenting our legislative activities.

General Operating Expenses

Since 1964, the cost of living and of doing business, according to the Bureau of Labor Statistics, has increased 21.9 per cent. If the activities and services of our Association had remained static since that time, our dues would have to be $91.50 per year just to stay even. That our activities have not remained static, but have, in fact, mushroomed, is evidenced by the fact that, in spite of a reduction in the number of committees from 51 to 35, the number of committee meetings increased from 145 in 1964 to a total of 206 in 1969—a net increase of 61.

During this same period of time the general operating expenses of the Association increased by 24 per cent, and the budget for the 1970-71 fiscal year calls for a further increase of 15.7 per cent in these expenditures.

Table I (below) is illustrative of the growing demands upon the financial resources of the Association. These are representative examples of promotional and other authorized expenditures.

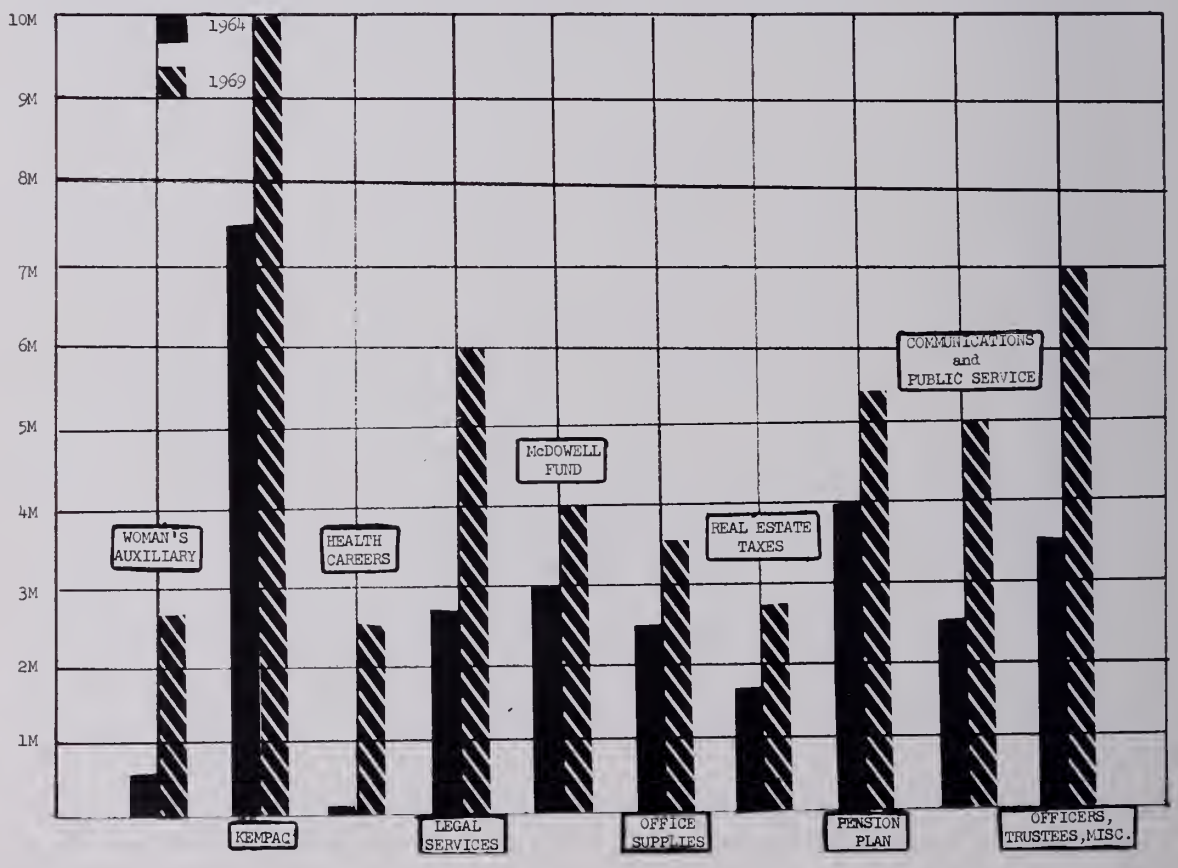
These and other programs with which KMA must become more deeply involved in coming years, such as peer review, ecology, health manpower and continuing medical education, demand that we provide the financial resources necessary to maintain our position of leadership.

Administrative Staff

The marked increase in Associational activities has placed an additional burden on both the administrative and office staffs. Field Services and legislative activities have been adequately and very competently staffed since the addition of a second man early in 1969, as a result of funds appropriated through the $5 dues increase voted by the House of Delegates in September, 1967.

The internal operations of the Association, however, have grown out of proportion and are straining the limits of endurability of two men. Additional staff will be needed in the very near future. In order to obtain and retain staff men of the caliber we demand, salaries commensurate with responsibility and competitive with the market are necessary. That our salary scale has been ridiculously low is evidenced by the fact that the annual compensation of our Executive Director was $7,000 below the average of his counterparts in the states we surveyed. It was, in fact, below the average for the No. 2 man in these states.

TABLE I



The additional work-load also demands additional secretarial and other office personnel. Here, again, wages must be commensurate with ability and competitive with the local market.

The Headquarters Office

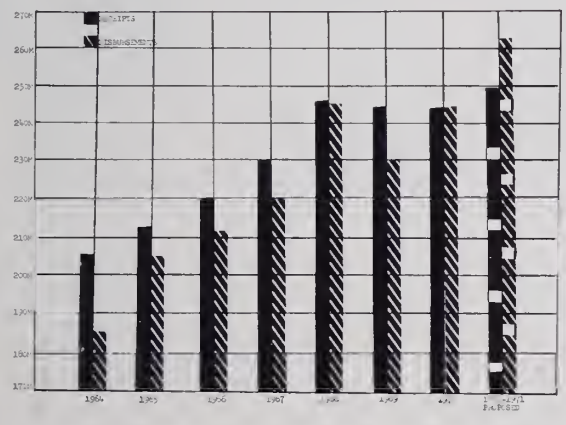
The Headquarters Office building of our Association is now approaching its 10th birthday. Normal wear and tear has taken its toll. Painting, redecorating, replacing draperies, rugs, etc. are necessary now for the preservation of the building and its appearance. With the increase of personnel and traffic in the administrative area of the building, accoustical tile and carpeting has been recommended to reduce noise and distraction and increase efficiency.

The present parking lot is totally inadequate and additional parking space is an immediate necessity.

Discussion of the Headquarters Office inevitably leads to the realization that the Association has already outgrown its present space. Offices designed for one person are now shared by two or three. The room originally assigned to the Auxiliary is now shared by KEMPAC. Space for storage and for more modern office equipment is practically nonexistent.

TABLE II

Total Income—Total Expense



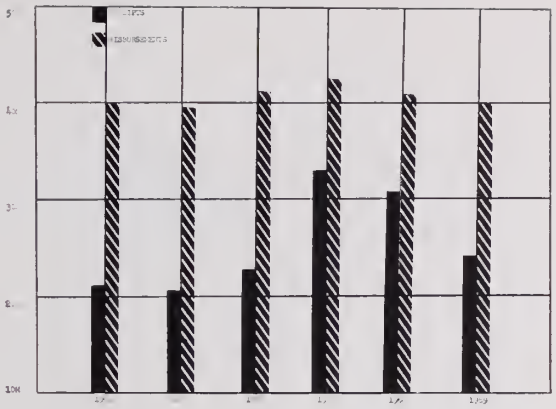
KMA must face the fact that an addition to the building must have high priority in the years just ahead, and it is a happy thought that those who planned the present building had sufficient foresight to make provision in the plans for such an eventuality. The constantly increasing activities and programs of the Association will necessitate a growth in staff if we are to meet our responsibilities; an enlarged staff requires more space in which to work efficiently. It is to be hoped that a new Building Committee will be appointed in the near future to initiate plans for such an addition, and it is recommended that the membership authorize the accumulation of funds to finance the construction.

Reserve Fund

Accepted policy in a non-profit organization such as KMA dictates that a reserve fund equivalent to

TABLE III

Journal



one year's operating expenses should be maintained at all times, in order to guarantee the financial stability of the organization. At the present time our reserve is $75,000 and it is fairly evident that it will be necessary to draw on that reserve during the next fiscal year in order to meet budgetary requirements. It is recommended that funds be set aside over the next five years to assure that our reserve will again be built up to an acceptable level.

Income

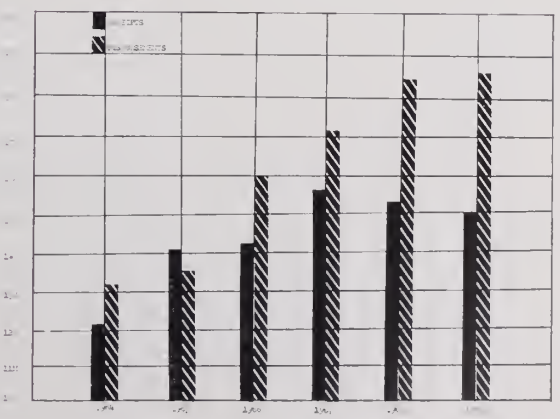
The income of the Association is derived primarily from three sources: the Journal, the Annual Meeting, and from dues.

There has been a steady decrease in income of the Journal account, as a result of a marked decrease in national drug advertising, and a steady increase in costs due to inflation, etc. This has resulted in a deficit of $14,000 in the Journal account in fiscal year 1969, and there is no reason to believe that the situation will improve in coming years.

The Annual Meeting income has shown a small but steady gain over the past six years, due to the aggressive promotion of our Administrative staff, but expenses have exceeded these gains in each of the past four years and the deficit for 1969 was $3,200.

TABLE IV

Annual Meeting



Membership dues accounts for 80 per cent of the Association's income. There has been a gradual increase in income from dues as a result of the gain of about 230 members in the past six years. This net gain, however, hardly covers the deficit in the 1969 Journal and Annual Meeting accounts. It is obvious, then, that the added revenue necessary to carry on the work of the Association must come from an increase in membership dues.

It is felt that there should be but one class of active members in the Association. The differential dues structure, allowing reduced dues for full-time teachers in medical schools, was a generous and worthwhile gesture when it was introduced, but it has been widely misunderstood and mis-interpreted as conferring a sort of "second-class citizenship" on our colleagues in academic medicine. We believe that the Association should make no distinction between doctors of medicine, regardless of their field of practice. The interest, cooperation and contributions by our colleagues in the two schools would seem to indicate that they concur in this position.

Discussion

The same inflationary pressures that have forced us to increase our fees in order to support and protect our families, to cover our increased overhead, to pay increased dues to other professional and civic organizations and to the country clubs to which we belong, have had their effect on KMA. It is only reasonable, then, that we should expect, and be willing, to increase our annual contribution to the organization that is dedicated to the best interest of the physician, the profession and our patients.

There are hundreds of members who are most knowledgeable of the programs and activities of the Association—through their service as officers, trustees, committeemen, and in other ways. For these physicians this article is unnecessary because they realize that their investment in KMA is probably the most valuable contribution to the profession that is in their power to make.

There are others, however—the majority, in fact—who may not be so knowledgeable, do not participate in KMA activities, do not really understand the Association's efforts in their behalf, and, unfortunately, have never had an opportunity to visit the Headquarters Office to see their organization "in action". It may be somewhat idealistic, but would be quite rewarding, if every member, and especially every delegate—who determines KMA policy—could spend one whole day in the Headquarters and observe our capable staff and some of our dedicated committees at their work.

We have been most fortunate in KMA to have been able to accomplish what we have done, to maintain the prestige and stature of our Association and to complete payments on our building, but reasonable men will agree that we have done these things while sacrificing programs and activities in which we should have been more deeply involved, while expecting and demanding more of our staff than we were willing to pay for, and, in the meantime, have used reserve funds rather than maintain a sound financial structure and build toward the future.

Let us not repeat the mistake we made in 1968 when we voted a token increase in dues and earmarked it for a specific purpose. Rather, let us view the broad picture. Let us be realistic and provide the financial stability to our Association that will assure its continued growth in the pursuit of our goals.

Recommendations

The Ad Hoc Committee has made an objective, in-depth study of the financial structure and the projected financial requirements of the Association. The Executive Committee and the full Board of Trustees have reviewed the findings and recommendations of the Committee and have voted to submit to the House of Delegates in September the following recommendations:

1. The dues for Active members of the Association shall be $130 per year, effective January 1, 1971—with the exception that

2. The dues for new members entering practice for the first time shall be $80 per year for the first three full years of practice.



Vhat she really needs, Doctor, is a shot of penicillin."

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EDITORIALS

Some Notes On Hypertension

PHYSICIANS doing general medical practice frequently encounter new patients that have an elevated blood pressure. Does the patient really have hypertensive vascular disease is a question that presents itself. If it is the decision that true hypertension exists then one has to decide what kind of diagnosis work-up will be done.

A number of blood pressure determinations should be made—preferably on different days—before a diagnosis of diastolic hypertension is made. There is considerable information to indicate that lability of the blood pressure often precedes established hypertensive vascular disease. This is not always the case, however, and an individual may have isolated elevations of the pressure under stress without developing established hypertension. Established essential hypertension of a mild to moderate degree may appear suddenly in a previously normatensive individual that has been followed for some other medical condition over an extended period of time.

A complete history and physical examination is done in all of these patients for two major reasons. One is to determine the presence and degree of arteriosclerotic vascular tension. The second reason is the determination, if possible, of a specific etiology of the hypertension. The history and physical, also, are determinations of the patient's general health and a specific evaluation of the cerebral circulation, retinal circulation, coronary circulation, condition of the abdominal aorta and the status of the peripheral circulation.

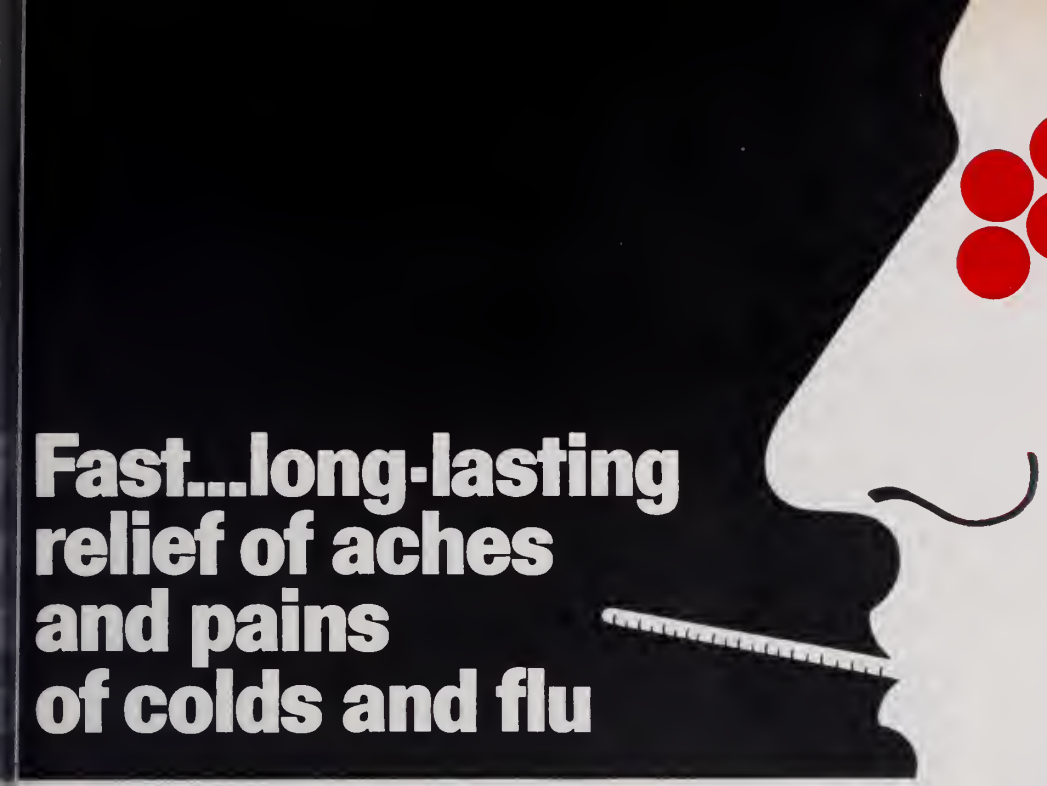
A diagnostic work-up of the hypertensive group of patients will reveal only a minority who have a specific etiology of the disease. However, such a diagnostic work-up is indicated in all of these patients. It is only in this way that the patient who has a specific cause will be discovered. Sometimes the history and the physical itself will indicate a specific cause of the hypertension. Examples of this would be coarctation of the aorta, pheochromocytoma, renal artery stenosis, polycystic renal disease, Cushing's Syndrome or primary aldosteronism. In each new hypertensive patient the question should be asked—does he have one of the specific causes of hypertension? Unless the different etiologies are specifically thought of, the diagnosis is apt to be missed in a small group of patients.

Certain laboratory tests may be considered routine in the evaluation of the hypertensive patients. These include urinalysis, blood count, serum cholesterol, chest X-ray, electrocardiogram, rapid sequence intravenous pyelogram, blood urea nitrogen and the serum electrolytes—sodium, potassium and chlorides. Some of these basic tests are not only diagnostic but serve as helpful baselines when therapy is instituted.

Information gained from the history, physical and routine laboratory tests may indicate additional diagnostic tests. Those most commonly indicated are those to evaluate adrenal function and renal blood flow. The measurement of catecholamines or vanillyl mandelic acid in the 24-hour urine specimen is done if there is any reason to suspect pheochromocytoma. If there is a possibility of primary aldosteronism a urinary aldosterone determination is done. To evaluate renal blood flow the radioactive renogram is used to supplement information obtained from the rapid sequence intervenous pyelogram. If there is any question after these procedures of the possibility or renovascular hyptertension—renal arteriography is done.

In summary: these brief and incomplete notes stress again the importance in the individual hypertensive patient of a thorough and complete history and physical—and a diagnostic evaluation.

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ORGANIZATION SECTION

General Sessions To Deal With Timely Topics At KMA Annual Meeting, September 22-24

The four general sessions of the 1970 KMA Annual Meeting will feature scientific presentations that are both timely and informative for today's physician. Guest speakers from across the country will address physicians on such topics as "Emergencies," "Cardio-Pulmonary Resuscitations," "Industrial Medicine," and "Tuberculosis."



Doctor Smith



Doctor Frazier

The three-day session, which will be held September 22-24 at the Louisville Convention Center, will also feature a Crackerbarrel Session on September 23, meeting of the 16 specialty groups, meetings of the House of Delegates of KMA, the President's Luncheon (see story next page), technical and scientific exhibits, an Orientation Program for new members, and meetings of the Woman's Auxiliary to KMA.

Participating in the opening session of the meeting on September 22 dealing with "Emergencies," will be Margaret H. D. Smith, M.D., New Orleans, La.; Shervert H. Frazier, Jr., M.D., New York, N. Y.; Donald J. Jaffar, M.D., Southfield, Mich., and J. Leonard Goldner, M.D., Durham, N.C.

A guest of the Kentucky Chapter, American Academy of Pediatrics, Doctor Smith will speak on "Croup." Professor of pediatrics and epidemiology at Tulane Medical School and Tulane School of Public Health, she is a graduate of Johns Hopkins School of Medicine. Doctor Smith is a member of numerous scientific societies and is on the Board of Scientific Counselors, NIH Division of Biologics Standards.

A 1943 graduate of the University of Illinois College of Medicine, Doctor Frazier is a guest of the Kentucky Psychiatric Association. He is currently a professor of clinical psychiatry at Columbia University College of Physicians and Surgeons.



Doctor Jaffar



Doctor Goldner

Doctor Frazier serves as secretary of the American Board of Psychiatry and Neurology and is on the editorial boards for several journals relating to psychiatry.

Speaking on "Urologic Emergencies" as a guest of the Kentucky Urological Association, Doctor Jaffar is a clinical professor of urology at Wayne State University School of Medicine. A 1968 graduate of the University of Michigan, Doctor Jaffar is the immediate past president of the American Urological Association.

Doctor Goldner, as a guest of the Kentucky Orthopaedic Society, will speak on "Vascular Injuries Associated with Fracture." A 1943 graduate of the University of Nebraska College of Medicine, Doctor Goldner is professor and chairman of the division of orthopaedic surgery at Duke University Medical Center. He is serving this year as the president of the Southern Medical Association.

Information regarding other speakers will be carried in future issues of *The Journal.*

Camp Set For Diabetic Children

The Kentucky Diabetes Association has planned its annual summer camp for diabetic children to be held August 9 - 22 at Camp Kysoc in Carrollton. The camp has been renamed the James Robert Hendon Camp for Diabetic Children in honor of its founder.

Physicians are urged to inform their diabetic patients and the parents of these children of this opportunity. Further information can be obtained by contacting the James Robert Hendon Camp for Diabetic Children, Fincastle Building, Louisville, Ky. 40202.

Trustee Districts Plan Meetings On Insurance, Peer Review

J. Campbell Cantrill, M. D., Georgetown, is planning a meeting of the Ninth Trustee District in Maysville in July. Physicians in this District will receive further information on this meeting in a later mailing.

Three Trustee Districts conducted annual meetings in May and June. The physicians in these districts heard presentations on liability insurance and peer review activities as requested by the KMA Board of Trustees.

The Sixth District met on May 12 at the Ramada Inn, Bowling Green, according to Paul J. Parks, M. D., KMA trustee. Douglas H. Jenkins, M. D., trustee for the Eleventh District scheduled the meeting of his District on May 21 at the Arlington Country Club in Richmond.

The program of the Twelfth District, which met June 10 at the Holiday Inn, Somerset, featured a discussion on peer review led by Marvin A. Bowers, Jr., M. D., Louisville, chairman of KMA's Claim and Utilization Review Committee. In addition, KMA Immediate Past President Henry B. Asman, M. D., Louisville, discussed KMA's future and details relating to a proposed dues increase. Robert N. McLeod, Jr., M. D., is Twelfth District Trustee.

Dr. Eblen Elected At KAGP Mtg., Drs. Bryant, Halcomb Honored

The Kentucky Academy of General Practice named Kenneth M. Eblen, M. D., Henderson, president-elect at its 19th Annual Scientific Assembly May 6-8 in Louisville. Benjamin F. Roach, M. D., Midway, was installed as president, succeeding John G. Rulander, M. D., Louisville, who presided at the meeting.



Doctor Eblen

This year's three-day session was dedicated to Charles G. Bryant, M. D., Louisville, for his "generous service through the years." Doctor Bryant was honored at the Academy's annual banquet and was presented an Academy gold seal ring.

Francis J. Halcomb, M. D., Scottsville, was chosen "Citizen-Doctor" of the year by the Academy. Doctor Halcomb, a 1943 graduate of the University of Louisville School of Medicine, is president of the school board at Scottsville and is credited with much of the planning of the new Allen County High School.

A general practitioner at Henderson, Doctor Eblen was graduated from the University of Louisville School of Medicine in 1948. A former KMA delegate and member of the KAGP Board of Directors, Doctor Eblen served as KMA vice president from 1964-65. He is a member of the American Society of Anesthesiologists and the Southern Medical Association.

Highlights of the annual session included an address by William J. Lederer, author of "The Ugly American." Mr. Lederer spoke on "Do You Want to Stay Married?" KAGP members and other physicians gave many informative scientific presentations, and Frank R. Lemon, M. D., Lexington, was awarded a plaque for the "outstanding scientific exhibit."

The meeting dates for next year's Annual Assembly are May 5 and 6 at the Louisville Convention Center and the Seelbach Hotel.

President's Luncheon To Feature Author of "At Your Own Risk"

Ralph Lee Smith, New York, N. Y., well known for his book exposing chiropractic, will be the featured speaker for the President's Luncheon during the Annual Meeting of the Kentucky Medical Association, according to Walter L. Cawood, M. D., Ashland, KMA president. Mr. Smith will discuss "I Get the Treatment," a presentation based on a chapter from his book "At Your Own Risk." The luncheon will be held in the Flag Room of The Kentucky Hotel on September 23.



Mr. Smith

A 1951 graduate of Swarthmore College, Mr. Smith is a former editor for the National Better Business Bureau and since 1958 has done a considerable amount of free-lance writing. He received the Russell L. Cecil Distinguished Medical Writing Award from the Arthritis Foundation in 1963 and the American Medical Association Medical Journalism Award, Magazine Category in 1965.

In addition to "At Your Own Risk," Mr. Smith has authored several other books, including "The Health Hucksters," "Getting to Know the World Health Organization," and "The Grim Truth About Mutual Funds." He also frequently contributes to magazines, newspapers and textbooks.

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Rural Scholarship Fund Reaches Million Dollar Milestone

A million dollar milestone was reached at the 24th annual meeting of the Rural Kentucky Medical Scholarship Fund held May 14. The Fund, established in 1946 for the purpose of providing a better distribution of physicians in rural Kentucky, has now loaned over one million dollars. There are now 161 loan recipients in practice in 86 Kentucky counties.

Loans to 10 first-year medical students and 23 upperclassmen, totaling $65,500, were approved by the Board of Trustees of the Fund at this meeting, according to C. C. Howard, M. D., Glasgow, Board chairman. Sixteen of the recipients have agreed to practice in counties listed as "critically in need of physicians."

Recipients receiving loans for the first time are Eddie L. Bunch, Williamsburg; James Cundiff, Shepherdsville; Robert Hendren, Louisville; E. Gary Hogan, Horse Cave; Benjamin Kutnicki, Hazel Green; Larry Maynard, Myra; Jerry Moore, Ft. Thomas; John Patton, Whitley City; William Powell, Lexington, and Joseph Skipworth, Bowling Green.

Douglas M. Haynes M. D., Louisville, dean of the University of Louisville School of Medicine and John Meisenheimer, Ph.D., Richmond, were elected as new members of the Fund's Board of Trustees.

Doctor Howard expressed at the meeting the Board's appreciation for the interest and support of Governor Louie B. Nunn, Health Commissioner Russell E. Teague, M.D., and the members of the Kentucky General Assembly.

KHA Elects Mr. Ahlstedt; Installs Mr. Frazier

Paul W. Ahlstedt, FACHA, administrator of Methodist Evangelical Hospital, Louisville was chosen by the Kentucky Hospital Association as its president - elect during the 41st Annual Convention held April 20-24 in Louisville. Also during the meeting, Chalmer H. Frazier, administrator of the Prestonsburg General Hospital, Prestonsburg, was installed as the Association's president.



Mr. Ahlstedt

A graduate of the University of Kansas and Northwestern University, Mr. Ahlstedt became administrator of Methodist Evangelical in 1957, when construction on the hospital was begun. He came to Louisville from the Wichita Falls General Hospital in Texas, where he was administrator for six years.

Guest speakers for the meeting included Jack A. L. Hahn, president-elect of the American Hospital Association and Brian J. Shea, M. D., director-general of medical services for South Australia.

Harold Peterson, administrator of Baroness-Erlanger Hospital, Chattanooga, Tenn., addressed the KHA General Session on "Stock-Owned Hospitals." Other hospital authorities participated in discussions on health manpower and education.

Dr. Kinsman Receives Honor At ACP Annual Meeting

J. Murray Kinsman, M. D., Louisville, was made a Master of the American College of Physicians at the Annual Meeting of the College in Philadelphia on April 13.



Doctor Kinsman

Doctor Kinsman, thought to be the only Kentuckian to be given this honor, is a former Govenor of the ACP for Kentucky and was a regent and first vice-president of the College. Dean of the University of Louisville School of Medicine from 1949 until 1963 when he became vice-president of the University, Doctor Kinsman has been very active in the affairs of medicine in Kentucky. He is also a former president of the Kentucky Heart Association and a past president of the Jefferson County Medical Society.

A native of Nova Scotia, Doctor Kinsman received his medical degree from McGill University in Montreal in 1922.

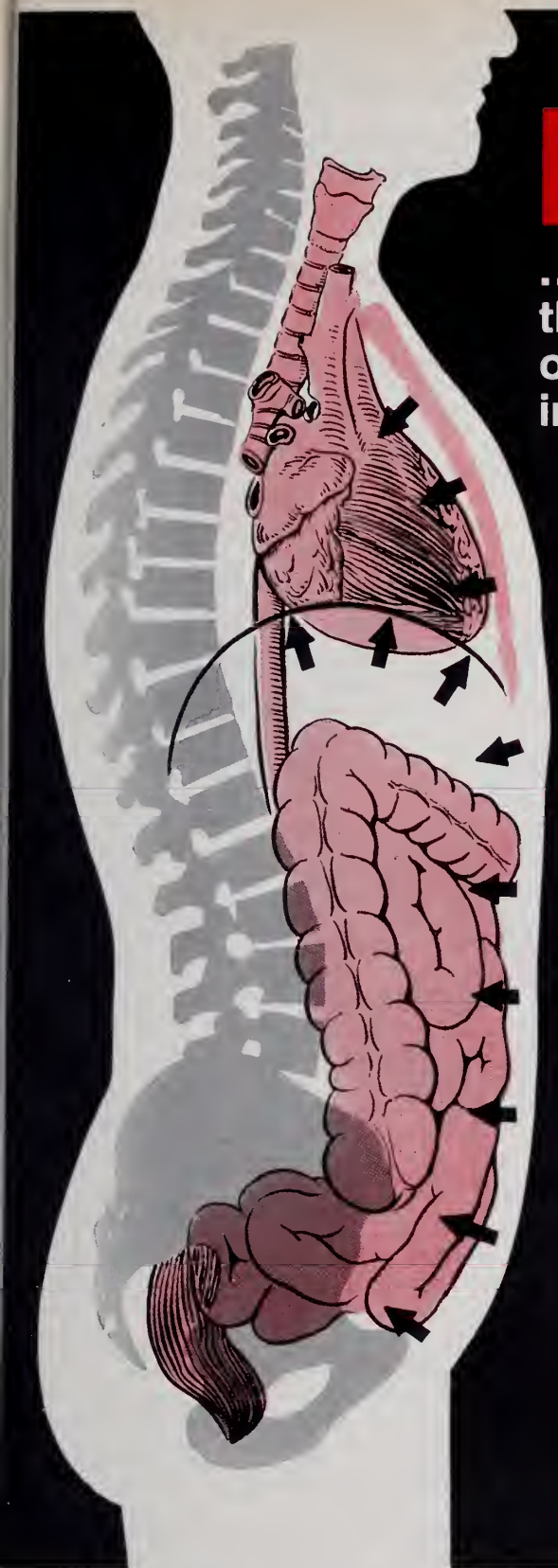
KMA To Utilize Housing Bureau For 1970 Annual Meeting

The Executive Committee of KMA has established that the Louisville Convention Housing Bureau will be available for use by all those planning to attend the 1970 KMA Annual Meeting. Forms for securing lodging reservations and for pre-registering at the Annual Session are included in this issue of the Journal. (see page 395)

In arriving at this decision, the members of the Executive Committee noted that an international convention will be held in Louisville at the same time as the KMA Annual Meeting this year and that the use of the Housing Bureau will aid members in obtaining rooms at their favorite locations.

Board Chairman, William W. Hall, M.D., Owensboro, urged all members to make their reservations early while good rooms are still available. Doctor Hall pointed out that members can cancel their reservations if they find they will be unable to attend the meeting, but those waiting until the last minute might have difficulty in obtaining a room.

You are urged to make your Annual Meeting room reservations now.



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Dosage: Adults and children over 12—one or two capsules daily. Children 6 to 12—one capsule daily. Give at bedtime for two or three days or until bowel movements are normal.

Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice,* 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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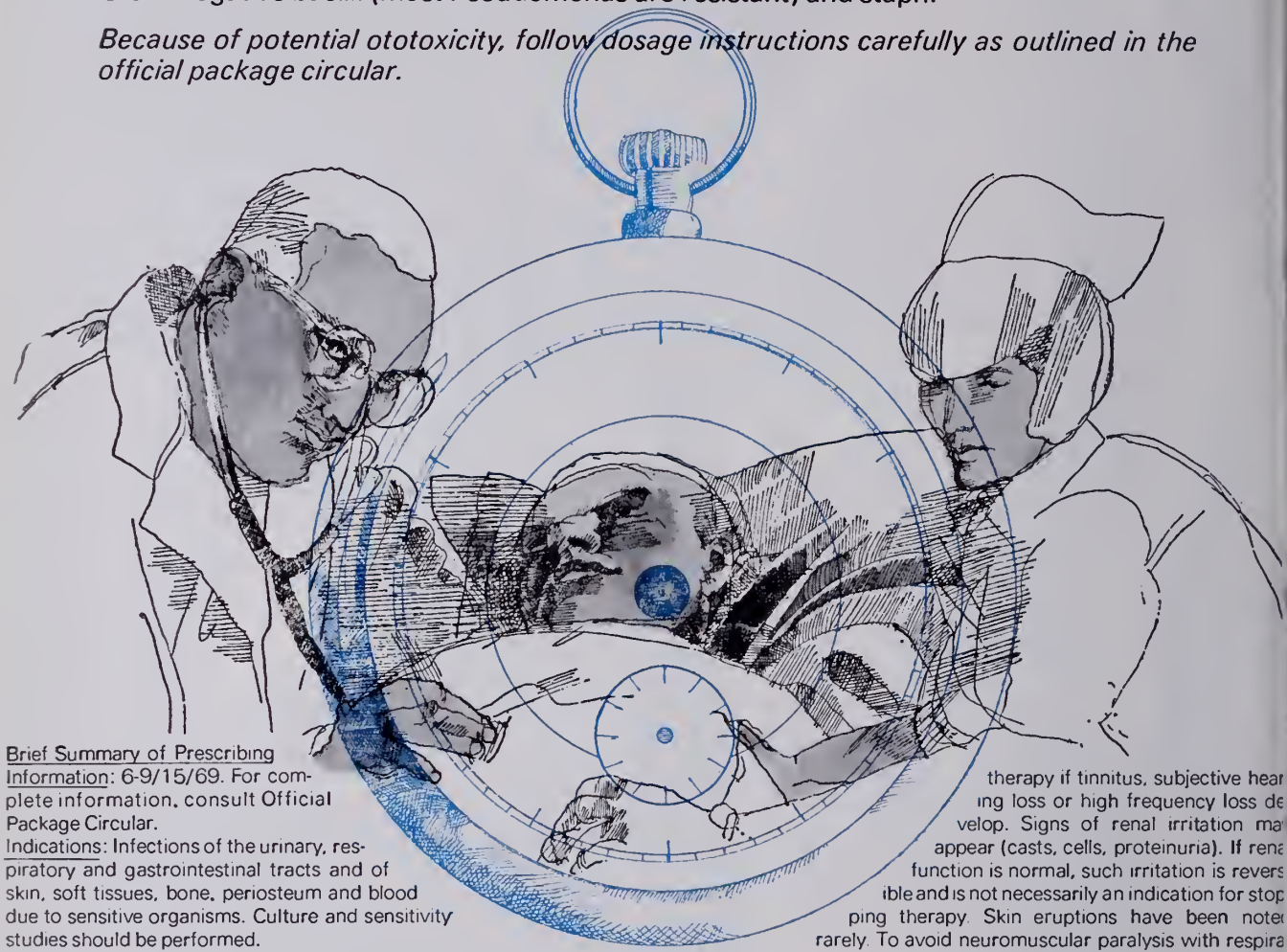
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10 years of experience confirm the continuing effectiveness of Kantrex® against many Gram-negative bacilli (most Pseudomonas are resistant) and staph.

Because of potential ototoxicity, follow dosage instructions carefully as outlined in the official package circular.



Brief Summary of Prescribing Information: 6-9/15/69. For complete information, consult Official Package Circular.

Indications: Infections of the urinary, respiratory and gastrointestinal tracts and of skin, soft tissues, bone, periosteum and blood due to sensitive organisms. Culture and sensitivity studies should be performed.

Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.

Warnings: Since the drug is excreted almost entirely by glomerular filtration, renal malfunction can cause abnormally high serum levels of kanamycin which may prove ototoxic. Assess renal function periodically, both before and during therapy. Renal dysfunction or pre-renal azotemia sharply increase the risk of ototoxicity and permanent deafness. In such cases decrease the size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. In older patients and patients receiving a total dose in excess of 15 Grams, watch carefully for signs of ototoxicity.

Precautions: If mycotic or bacterial superinfection occurs, discontinue kanamycin and initiate appropriate therapy. Cumulative ototoxic effects may be produced by concurrent or consecutive use of other ototoxic drugs. High doses may cause irritation at injection sites. The drug *should not* be physically mixed with other antimicrobials.

Adverse Reactions: Severe irreversible hearing loss may occur. Stop therapy if tinnitus, subjective hearing loss or high frequency loss develop. Signs of renal irritation may appear (casts, cells, proteinuria). If renal function is normal, such irritation is reversible and is not necessarily an indication for stopping therapy. Skin eruptions have been noted rarely. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in postoperative patients until recovery from anesthesia and muscle relaxant is complete.

Dosage and Administration: The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gram daily and should not exceed 1.5 Gram even in the heaviest patients. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours.

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Kentucky Medical Association — Annual Meeting — September 22-24, 1970

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Digest of Proceedings, Board of Trustees

April 8, 1970

The third meeting of the Board of Trustees was held on April 8, 1970, in conjunction with the KMA Interim Meeting in Gilbertsville. The meeting opened with a number of reports, including the report of the President, Walter L. Cawood, M.D., who commented on the recent session of the Kentucky General Assembly. Budget Committee Chairman, Ballard W. Cassady, M.D., presented the 1970-71 proposed Fiscal Year budget which was adopted.

The report of the Ad Hoc Committee on Finance was presented by Henry B. Asman, M.D., chairman. The report, calling for the KMA House of Delegates to consider a dues increase at the 1970 KMA meeting, was adopted by the Board.

J. Thomas Giannini, M.D. summarized the activities relating to the campaign of Robert C. Long, M.D. for President-Elect of AMA and urged continued support of all members for Doctor Long's candidacy.

The Chairman for State Affairs of the KMA Committee on Legislative Activities, Fred C. Rainey, M.D., reported at length on the activities of the 1970 Kentucky General Assembly. He pointed out several changes which had taken place due to the implementation of a new committee system, and noted there were nearly 1,400 Bills introduced during the Session of which 10% were medically oriented.

Nominations were confirmed for submission to the Governor for membership on the Governor's Advisory Council for Medical Assistance, the Hospital Licensure Council, and the Board of Nursing Education and Registration.

Considerable discussion was held concerning the activities of the Plans and Development Committee. Thornton E. Bryan, M.D., chairman, reported the Committee had a lengthy and informative session which covered many matters of importance and presented to the Board eight recommendations set forth by his committee. These recommendations included changes in such areas as the Orientation Program, KMA Senior Day Program, urging the KMA Journal to publish articles on liability insurance, reaffirmation of KMA opposition to "screening panels," and a proposal that KMA establish a Committee on Medical Economics.

Marvin Bowers, M.D., chairman of the Claims and Utilization Review Committee, presented a number of recommendations concerning his committee's activities. More detailed recommendations are to be brought back to the Board regarding the changes, membership and responsibility of a new peer review segment of Claims and Utilization Review.

The Commissioner of Health, Russell Teague, M.D., spoke of the great number of claims filed with Workmen's Compensation regarding Coal Workers Pneumoconiosis. This matter is now under study in the Department of Health and assistance from KMA and the private sector of medicine was solicited. It was agreed to refer this subject to the Ad Hoc Committee to Study Occupational Pulmonary Disease which would have the expertise to deal with the problems set forth by Doctor Teague.

The Board heard and adopted proposed recommendations of the Executive Committee regarding changes in the KMA Orientation Program. A change in KMA Bylaws to reflect an additional year of Orientation opportunities will be voted upon by the House of Delegates at the 1970 Annual Meeting.

William W. Hall, M.D., read a report on the "Mental Health Care for the Poor" Conference held in Chicago in March, 1970. KMA was represented at this meeting by John W. Baird, M.D., chairman



Physicians attending the April 9 morning session of the 1970 KMA Interim Meeting at Kentucky Dam Village State Park paid close attention to the panel discussion on Peer Review. Speaking to the group here is Vincent Santare, M.D., Munster, Ind., a member of the Board of Trustees of the Indiana State Medical Society. The other panel participants, from left to right, are Walter L. Cawood, M.D., Ashland, KMA president and moderator of the Peer Review panel; John W. Koon, Louisville, executive secretary of the Kentucky Farm Bureau Federation, and Marvin A. Bowers, Jr., M.D., Louisville, chairman of the KMA Claims and Utilization Review Committee.

of KMA's Committee on Community and Rural Health. The report was accepted for information.

AMA Trustee, Robert C. Long, M.D., reported on current activities and programs of the AMA. He also thanked the Board members for their support of his candidacy for President-Elect of AMA. Following this, a brief report on the AMA Conference on "Mental Health Care for the Poor" was presented by the chairman.

Doctor Hall reviewed the minutes of the March 26 Executive Committee meeting, and emphasized the section dealing with a Medicaid Participating Physician form which has been proposed by the Kentucky Department of Health. Several objections which KMA has to the form were pointed out to the Board during the discussion. Legal Counsel and Thomson R. Bryant, Jr., M.D., chairman of the Physicians Advisory Committee on Title XIX, participated in the discussion and pointed out that a physician could sign the form in its present composition; however, it was not to be construed whatsoever as an endorsement by KMA. The Commissioner of Health stated that no such form or cover letter would be distributed until it had been cleared with the Physicians' Technical Advisory Committee.

The Medicine and Religion Representative to AMA, J. Campbell Cantrill, M.D., reported on the activities of the AMA Committee and requested some changes relating to KMA's Committee on which action was delayed pending more study.

George F. Brockman, M.D. reported on activities of the Comprehensive Health Planning Committee and spoke briefly concerning legislation regarding a new TB Control Statute which was passed during the 1970 General Assembly.

A resolution concerning "Physician's Assistant" programs was passed and a request was made that the Board endorse a specific coronary care training program which is being used in hospitals in surrounding states. No action was taken pending further study.

The meeting closed with Doctor Hall reminding the Board of Trustees of the Washington Dinner, scheduled for June 1-2, 1970 and requesting staff to investigate locations for the 1971 Interim Meeting.



Following their presentations on the panel on the Physician's Assistant at the 1970 Interim Meeting, Robert W. Ewer, M.D., Galveston, Tex. (left) and D. Robert Howard, M.D., Durham, N.C. (center) talk with Walter I. Hume, Jr., M.D., Louisville, who moderated this discussion.



Luncheon speaker J. Ed McConnell emphasizes a particular point during his address to the physicians attending the 1970 Interim Meeting. Mr. McConnell, president of Kentucky Physicians Mutual and Blue Cross Hospital Plan, discussed "Blue Cross-Blue Shield in Kentucky—Today."

Newborn Symposium Scheduled

The department of pediatrics of the University of Louisville School of Medicine will hold its Fourth Annual Newborn Symposium on November 5-6. The theme for this year's program is "Metabolic Problems in the Newborn."

Participating in this two-day session will be Marvin Cornblath, M. D., Louis Gluck, M. D., Harry H. Gordon, M.D., Charles Lowe, M.D., Grant Morrow, II, M. D., Gerard B. Odell, M. D., Leo Stern, M. D., Robert Usher, M. D. and the faculty of the department of pediatrics of the Louisville school. For further information on the symposium contact Billy F. Andrews, M. D., professor and chairman, department of pediatrics, 226 East Chestnut Street, Louisville, Ky. 40202.

ADMINISTRATOR—Needed for OEO Comprehensive Health Program in Eastern Kentucky. Four (4) or more years experience in Public Health or Administration in a closely related field. Must be able to work with community activities, organizations and people in area State and Federal Community Action Agencies—salary negotiable—based on training, experience and prior income. Reply—William B. Cook, M.D., Chairman of the Board, First Avenue, Prestonsburg, Kentucky 41653. Please reply by June 30, 1970.

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Clinic Appoints Med. Director

Leo L. Leveridge, M. D. was recently appointed as medical director of the Daniel Boone Clinic, Harlan. A 1940 graduate of McGill University Faculty of Medicine, Doctor Leveridge succeeds John H. Willard, M. D., Harlan, who retired in January.

Doctor Leveridge will be concerned with the training of surgical residents, will serve as a consultant in the continuing medical education of the staff and in the introduction of medical systems and computer services.

In Memoriam

MAX E. BLUE, M. D.

Richmond

1905-1970

Max Ewart Blue, M. D., 64 died on January 15 after a long illness. A general practitioner, Doctor Blue practiced in Richmond since 1941. A 1930 graduate of the Indiana Medical School, Doctor Blue served for five years as an Army medical officer.

A former president of the Madison County Medical Society, Doctor Blue was associated with the Phi Chi medical fraternity and was a former health officer in Richmond.

ARMAND E. COHEN, M.D.

Louisville

1900-1970

Armand Earl Cohen, M. D., 69, died April 23 of head and internal injuries due to an automobile accident on that date. A Louisville allergy specialist, Doctor Cohen was a 1928 graduate of the University of Louisville School of Medicine. Active in the affairs of medicine, Doctor Cohen was president of Jewish Hospital in 1951 and was grand consul of Phi Delta Epsilon medical fraternity in 1967. A clinical professor at the University of Louisville, Doctor Cohen was a former president of the Louisville Society of Medicine.

MEDICAL DIRECTOR—For on going OEO Comprehensive Health Care Program. Challenging position in delivery of comprehensive health care in a rural county in Eastern, Kentucky. Full time position—salary negotiable—based on experience, and previous salary. Requirements—licensed physician, practical experience and public health preferred, or other related community health program and activities. Apply by June 30, 1970 to William B. Cook, M.D., Chairman of Board—First Avenue—Prestonsburg, Kentucky 41653.

WARD LEWIS CORUM, M. D.

Louisville

1907-1970

Ward Lewis Corum, M. D., died on March 24 at the age of 62. A 1936 graduate of the University of Louisville Medical School, Doctor Corum practiced internal medicine in Louisville.

During World War II, Doctor Corum served overseas as a major in the Army Medical Corps. He was a member of the Jefferson County, Kentucky and American medical associations.

CHARLES T. MORAN, M.D.

Louisville

1901-1970

Charles Thomas Moran, M. D., 68, a Louisville ophthalmologist for 25 years, died April 18. Doctor Moran was a graduate of the University of Louisville Medical School and was advisory chairman of the Kentucky advisory committee of the National Society for Prevention of Blindness. He was a member of the American College of Surgeons and the Academy of Ophthalmology.

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ACS To Meet In October

The 56th Annual Clinical Congress of the American College of Surgeons will be held in Chicago October 12-16. Included on the program are 18 postgraduate courses, more than 260 research-in-progress reports and panel discussions in general surgery. For more information on the Congress and for official registration forms contact Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

KMA Committee Reports

KMA Community and Rural Health Committee

KMA Headquarters — March 26, 1970

John M. Baird, M. D., Danville, Chairman

The KMA Community and Rural Health Committee met recently and made plans for Community Health Week in Kentucky, May 3-9, 1970. Designed to replace Immunization Week, which has been sponsored by the committee in the past, Community Health Week will focus public attention on the value of physical fitness and good health.

Other agenda items discussed included Home Health Care Programs, the status of tuberculosis in Kentucky, highway safety and mental health programs.

NEWS ITEMS

David S. Nightingale, M.D., specializing in cardiovascular and thoracic surgery, is now practicing in association with Doctors Harter, Bryant, Davis, and Rubel in Louisville. A 1956 graduate of the University of Louisville School of Medicine, Doctor Nightingale completed his internship and residency at the University of Pennsylvania. Doctor Nightingale served on the faculty of the University of Florida from 1967-69 before returning to Louisville.

John A. Darpel, Jr., M.D. is now practicing in association with Doctors Jacobs and Stevie in Erlanger. Specializing in obstetrics and gynecology, Doctor Darpel graduated in 1963 from St. Louis University. After serving his internship at St. John's Hospital, St. Louis, Doctor Darpel served in the Air Force as a captain. He then took his residency at Good Samaritan Hospital, Cincinnati, which he completed in 1969.

Charles L. Langsam, M.D. is clinical director at Waverly Mental Health Center. A graduate of Washington University, St. Louis, Doctor Langsam completed his residency at Bellevue Hospital,, New York City. A lieutenant colonel in the Army Medical Corps for five years. Doctor Langsam previously practiced psychiatry in Ohio, California and Indiana.

Veryl F. Frye, Jr., M.D., a general surgeon, is now practicing with Doctors Weddle and Hill, Somerset Clinic. A 1962 graduate of the University of Louisville School of Medicine, Doctor Frye completed his internship and residency in Louisville hospitals.

R. Wathen Medley, Jr., M.D., an internist, has set up practice in Owensboro. He is a 1963 graduate of Tulane University Medical School and completed his internship at Methodist Hospital, Dallas, before going into the Army as a flight surgeon in 1964. Doctor Medley completed his residency in 1969 at Medical College of Virginia, Richmond.

Paul Glenn Young, M.D., is now in practice with James McClellan, M.D., Lexington. A pathologist, Doctor Young graduated from the University of Louisville School of Medicine in 1963. He took his internship at Johns Hopkins Hospital and his residency at the Memorial Hospital for Cancer and Allied Diseases, 1967-69.

Samuel L. Cooper, M.D., is now in practice with George I. Udhe, M.D., Louisville. An otolaryngologist, Doctor Cooper graduated from the University of Louisville School of Medicine in 1963, and completed his internship and residency at St. Joseph Infirmary.

John K. McBain, M. D. is director of nuclear medicine and associate professor of radiology and medicine at the University of Louisville School of Medicine. A 1956 graduate of Stanford University, Doctor McBain completed four years of residency in internal medicine. Before coming to Louisville last year, Doctor McBain practiced in Dayton.

John L. Simmons, M. D. is a member of the faculty at the University of Kentucky College of Medicine in the urology division. Doctor Simmons graduated from Washington University in 1951 and completed his internship at the Medical College of Virginia and his residency at North Carolina Memorial Hospital. Before coming to the University of Kentucky, Doctor Simmons taught at Vanderbilt University in Nashville.

Josephine W. Richardson, M. D. is now in association with Thomas Kelley, Jr., M. D., Louisville. Specializing in physical medicine and rehabilitation, Doctor Richardson is a 1949 graduate of the University of Buffalo. Before joining the faculty of the University of Louisville School of Medicine, Doctor Richardson was clinical director of the department of physical medicine and rehabilitation at Jefferson Medical College, Philadelphia, Penn.

Nuhad D. Dinno, M. D. is a faculty member of the department of pediatrics at the University of Louisville School of Medicine. A 1961 graduate of the University of Baghdad, Doctor Dinno completed her internship in Iraq and took her residency in Iraq, Great Britain and the United States from 1962-1967.

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1970 Annual Meeting — Kentucky Medical Association

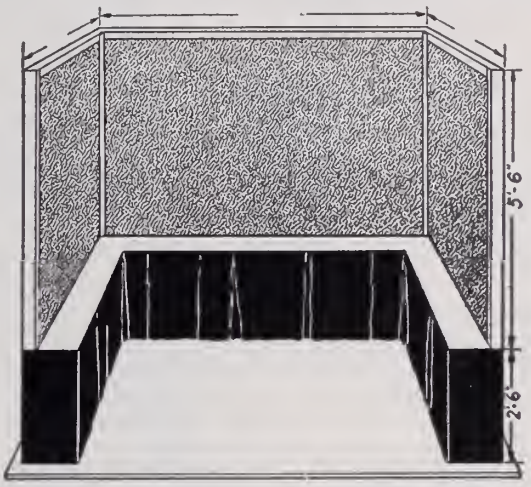
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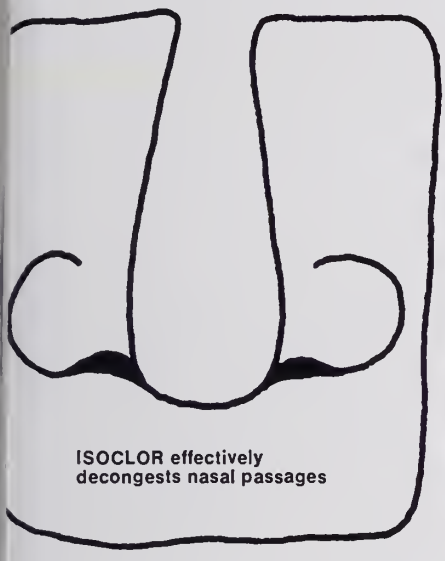
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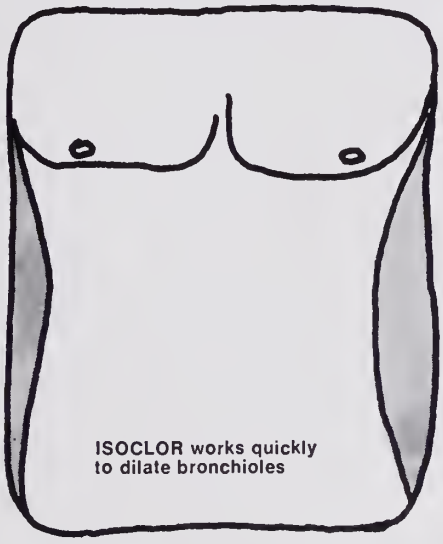
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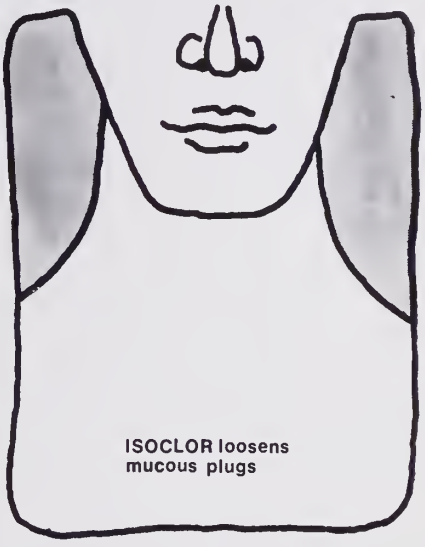
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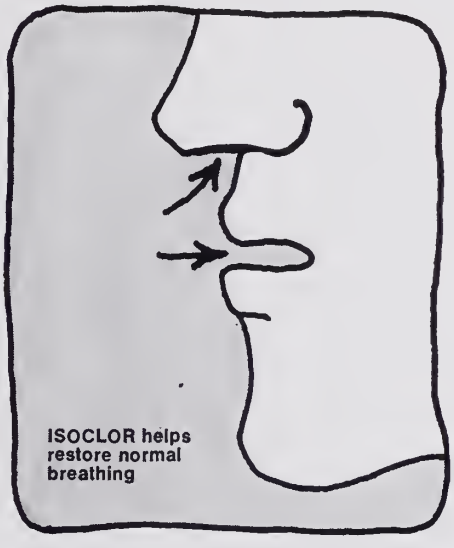
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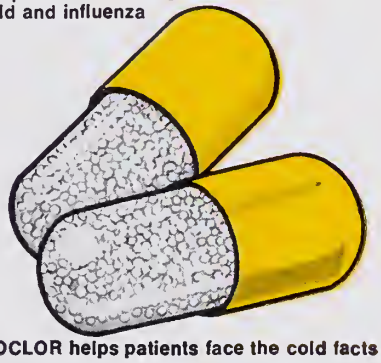


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30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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VOLUME 68 JULY 1970 NUMBER 7

The Journal of The KENTUCKY Medical Association



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KMA 1970 Annual Meeting
September 22-24
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Equipped for the thyroid emergency?

When an ambulance arrives with the unexpected patient presenting the classical picture of myxedema coma, is your hospital suitably equipped? It is if SYNTHROID® (sodium levothyroxine) injectable is at hand. You are also ready to conveniently handle post-operative thyroid medication situations until oral therapy can be reinstated.

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INDICATIONS: SYNTHROID (sodium levothyroxine) INJECTION is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. It is indicated in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. When o patient does not respond to oral therapy, SNYTHROID (sodium levothyroxine) INJECTION may be administered intravenously.

PRECAUTIONS: As with other thyroid preparations, overdose may cause diarrhea or cramps, nervousness, tremors, tachycardia, insomnia and continued weight loss. These effects may become apparent in from 4 days to three weeks. Therefore, patients should be kept under close observation. Medication, in such cases, should be stopped for 2 to 6 days, then resumed at a lower level. In patients with diabetes mellitus, look for possible changes in metabolic activity which may affect insulin or other antidiabetic drug dosage requirements.

CONTRAINDICATIONS: Thyrotoxicosis, acute myocardial infarction.

SIDE EFFECTS: Side effects are secondary to increased rates of body metabolism: sweating, heart palpitations with or without pain, leg cramps, weight loss, diarrhea, vomiting and nervousness. Myxedematous potients with heort disease have died from abrupt increases in dosage of thyroid drugs. In most cases, a reduction in dosage followed by a more gradual adjustment upward will indicate the patient's dosage requirements without the appearance of side effects.

DOSAGE AND ADMINISTRATION: In myxedematous stupor or coma, with no evidence of severe heart disease, 200 to 400 mcg. of SYNTHROID (sodium levothyroxine) INJECTION may be administered intravenously utilizing a solution containing 100 mcg. per ml. Detectable effects are usually observed by the sixth hour after injection and are fully appreciated during the following day. A repeat injection of 100 to 200 mcg. may be given on the second day if significant improvement has not occurred. The intravenous use of sodium levothyroxine in myxedematous coma is advantageous because it produces a predictable increase in the concentration of protein-bound iodine, eliminates the need for multiple doses until oral therapy is reinstated, circumvents the uncertainty of oral absorption, and avoids the risk of pulmonary aspiration.

SUPPLIED: SYNTHROID (sodium levothyroxine) INJECTION is supplied in 10 ml. vials containing 500 mcg. of lyophilized active ingredient and 10 mg. of Mannitol, N.F.; a 5 ml. vial containing Sodium Chloride Injection, U.S.P. is provided as diluent.

Also supplied as SYNTHROID (sodium levothyroxine) TABLET in color coded compressed tablets, and in seven strengths: 0.025 mg. (orange), 0.05 mg. (white), 0.1 mg. (yellow), 0.15 mg. (violet), 0.2 mg. (pink), 0.3 mg. (green), ond 0.5 mg. (blue). Each strength is supplied in bottles of 100 and 500 tablets.

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Literature on indications and dosage available on request.

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References:

(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.

Volume 68 • July 1970

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Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

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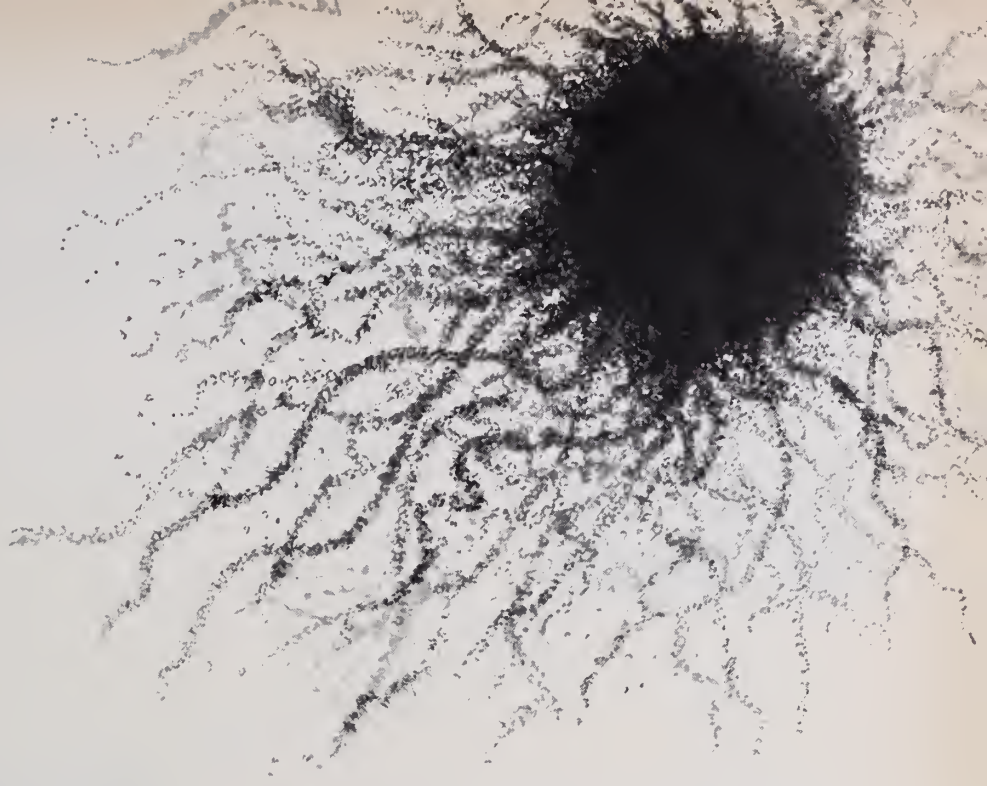
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Corticosteroid therapy week after week.

then antibiotic therapy last week.

and monilial overgrowth this week.

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

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Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MESSAGE FROM THE PRESIDENT



The Umbrella Approach

"United We Stand" is a familiar phrase to all Kentuckians. It is an excellent theme for the medical profession . . . . in Kentucky or anywhere.

It seems apparent to many people that there is a concerted effort within government circles and the communications media to degrade the medical profession in an attempt to bring about radical changes in our health care delivery system. Changes, which in fact, would not be in the interest of the patient or the profession. These attacks are being made on the profession as a whole and not on any particular segment of it.

The Kentucky Medical Association, through its Plans and Development Committee, hopes to stimulate action that will solidify medicine in Kentucky as one strong unit. Groundwork is being laid to bring about results that would create a more powerful and unified voice of medicine. Legislative matters is only one of many advantages foreseen.

A second meeting of the committee was held last month to discuss the prospect of having administrative services for all specialty groups housed at the KMA Headquarters. Such a cooperative effort should result in better coordination, implementation of programs, economies in the sharing of equipment, supplies and other physical matters as well as better efficiency from the sharing of ideas and experience.

I applaud this approach as I think it is best for all: the physician, the profession and the public. I hope all medical groups in Kentucky will take a serious look at this approach of uniting together for many purposes and help prohibit any possibilities of fragmentation. Medicine must strengthen its united bond.

Walter L. Cawood

PUBLIC HEALTH PAGE

The Third Pollution—Solid Waste

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

Kentucky's Solid Waste Program, located in the Division of Environmental Health of the Kentucky Department of Health, is the agency designated by the Governor to represent the State for all purposes of Federal Law 89-272.

For the last three years the personnel in this Program have chiefly been busy developing Kentucky's comprehensive solid waste management plan. Based upon a detailed analysis of the existing facilities and methods used for collection, storage and disposal, the plan outlines the basic problems that must be solved, the needs that must be met and objectives that must be reached if Kentucky is to achieve progress in eliminating the dangers to our environment from the improper handling of solid waste.

Health Hazards

Solid waste is too often thought of as being only household wet garbage and trash, when in reality, it is almost everything that man uses. In addition to being his household garbage and refuse, it consists of all the associated wastes from manufacturing and industry, the commercial waste from stores and restaurants, agricultural waste, timber waste from the strip mines and lumber industries, demolition and construction wastes, and worn out and discarded household, commercial and office equipment and appliances.

Included in the health hazards associated with solid waste are the dangers from the burning of waste creating air pollution, from polluting ground and surface water, from providing fly and other insect breeding places, and rat harborage, and other associated problems.

In addition to the direct detriments to health, the aesthetic deterioration and decrease in value of property adjacent to improperly operated disposal sites—roadside litter and open dumps—represent a very real cost to society.

It is very likely that the difference in cost between approved disposal methods and those disposal methods now being practiced in the State would be offset in the increase in tourism. The effect of acceptable solid waste disposal systems is also felt in the ability of the State to attract new industry.

Regional Operation Needed

Many counties in this State do not have sufficient population and resources to create disposal sites, collection systems and litter barrel programs, and must of financial necessity become part of a regional program to accomplish their desired goals. There is a real reluctance on the part of many political subdivisions to become a part of these regional bodies; however, the public demand for services that will protect their environment is increasing, along with an increasing realization by the public that the cost to protect their environment must be borne.

Solid waste is increasing on a per capital basis at a rate almost twice the rate by which the population is growing. Failure to solve some of the problems now will lead to even greater future problems.

New technology is lagging in the disposal, collection and storage methods and much needs to be accomplished in the engineering science of waste handling. New and better methods that are financially feasible need to be developed in the recycling of solid wastes. It has been said that solid waste materials are "re-

†*This article was prepared by: Samuel N. Johnson, Jr., P. E., Director, Solid Waste Program, Division of Environmental Health, Kentucky State Health Department, 275 East Main Street, Frankfort, Kentucky 40601*

sources out of place."

The solutions to the solid waste problems can be simply outlined. No plan of solution will work, however, without public education and public awareness. These must then be translated into a desire and willingness on the public's part to bear the cost, and demonstrated initiative on the part of health professionals and public officials to provide the necessary leadership in implementation of corrective programs.

Health officials at the local level will need to strengthen their position against violators of the present solid waste laws and initiate the necessary action in their local courts to correct these violations. The 1970 General Assembly by passage of House Bill Number 384 greatly strengthened the position of local health officials in opening the prosecution of violators to any person, which of course includes local health officials where heretofore prosecution had to be by the State Health Department.

Information Available

The Kentucky Solid Waste Program can assist in many ways by conducting programs for local medical societies, civic service clubs, schools and similar organizations. We can also attend city council and fiscal court meetings to explain the present law and regulations. We have movies to show how disposal sites should be operated.

During the 1971 fiscal year, your State program will develop as many planning and inspection aids for local health officials as time and money will permit, to assure uniformity and competence in inspection of disposal sites through the State.

Working alone, neither health professionals, nor local officials, nor Solid Waste Program personnel can expect to accomplish much. Working together as a team, we can expect continued progress and eventual solutions to our solid waste problems.

Private Practice Opportunity in Lexington, Kentucky

Drawing from 700,000 population. Five modern hospitals with open staff privileges including University of Kentucky Hospital. We need 2 Family Physicians, 1 Radiologist, 2 Internists, and 1 General Surgeon to furnish the required services. Write Box 7264, Lexington, Kentucky 40502.

Brief Summary of Prescribing Information– 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

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Easy-to-live with cost of therapy. The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

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hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.



From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

Case 7-69. This 24-year-old divorced white gravida 2, para 1 was rushed to the emergency room after she had been seen by a private physician for profuse vaginal bleeding, severe lower abdominal pain and a high temperature. In the emergency room, March 25, 1969, her blood pressure was 108/40, pulse 156, respiration 36, labored. She had cyanosis of all distal extremities and profuse vaginal bleeding. She admitted that she had had a criminal abortion performed on March 23 in another city, stating she was about two months pregnant. When she began to bleed profusely passing the large clots she informed her father of the facts.

She had been treated with X-ray (supra voltage) at The Mayo Clinic and the Cleveland Clinic for Hodgkins Disease in 1966 and had been followed with no recurrence.

On admission to the hospital her temperature was 102, pulse 156, respiration 36, blood pressure 103/40. She appeared acutely ill with cyanosis of her hands, legs and feet. She was dyspneic and had labored respiration. Her abdomen was tender, bowel sounds were present. Vaginal examination revealed the vagina filled with blood and clots. The cervix was dilated with placental tissue trapped in the cervix. The uterus was the size of an eight-ten week gestation, however, it was hard to examine patient due to her pain.

A D&C was performed, shortly after she was admitted, under general anesthesia. Examination revealed the cervix dilated two to three fingers with the cord hanging in the vagina. The placenta was trapped in the cervix and the uterus was enlarged compatible with eight weeks gestation. There was no evidence of tenaculum marks on the cervix or any lacerations. The anterior lip of the cervix was held with a ring forceps and with another, the placental tissue removed. The uterus was then explored and as far as could be determined, there was no evidence of any perforations of the uterus. A large sharp curet was used with removal of a minimal amount of decidual appearing tissue. The uterine cavity was wiped clean and the uterus contracted well. A two-inch iodoform gauze pack was placed in the endocervical canal. She withstood the procedure well despite her critical condition. The prognosis was considered guarded.

Her condition seemed improved when she was returned to her room, however, the following morning she developed severe respiratory distress. It appeared clinically that she had some acute pulmonary problem either an infarct or embolism; however, x-rays revealed findings typical of lipoid pneumonia. It was then determined the abortion had been performed by the injection through the catheter of mineral oil and distilled water. The patient stated immediately following this procedure she had a severe paroxysm of coughing. General supportative treatment was maintained during her hospitalization.

She received a blood transfusion, but she never recovered from the respiratory embarrassment. Her condition remained critical for the next three days and at 10:15 p.m. the 28th of March she suddenly expired. An autopsy was performed.

The final pathologic diagnosis was:

(1) Massive bilateral pulmonary oil embolism and generalized oil embolism.
(2) Extensive fibren thrombi of multiple organs specifically the uterus, kidneys and to a lesser extent of other organs.
(3) Acute hemorrhagic pulmonary edema.
(4) Acute cardiac dilatation.
(5) Visceral evidence of cardiac failure manifested by central zone degeneration and necrosis of the liver.
(6) Acute endometritis.
(7) Incidental Hodgkins Disease of the liver.

Patient died from massive pulmonary oil embolism.

COMMENT

The Committee classified this as a direct obstetrical preventable death due to induction of abortion by mineral oil with subsequent embolization. The Committee questioned the reason or effectiveness of the cervical packing, since the cervix was already dilated. Perhaps she might have lived if she had been put on a respirator to maintain adequate pulmonary ventilation to carry her over the critical period of lipoid pneumonia. The tragedy of criminal abortion rates as a leading cause of maternal mortality in many areas of this country has been documented. Perhaps liberalization of abortion laws with resultant hospital abortion under optimum circumstances will prevent or reduce the number of criminal abortions. However, some would argue that abortion on request may not eradicate the criminal abortion rate.

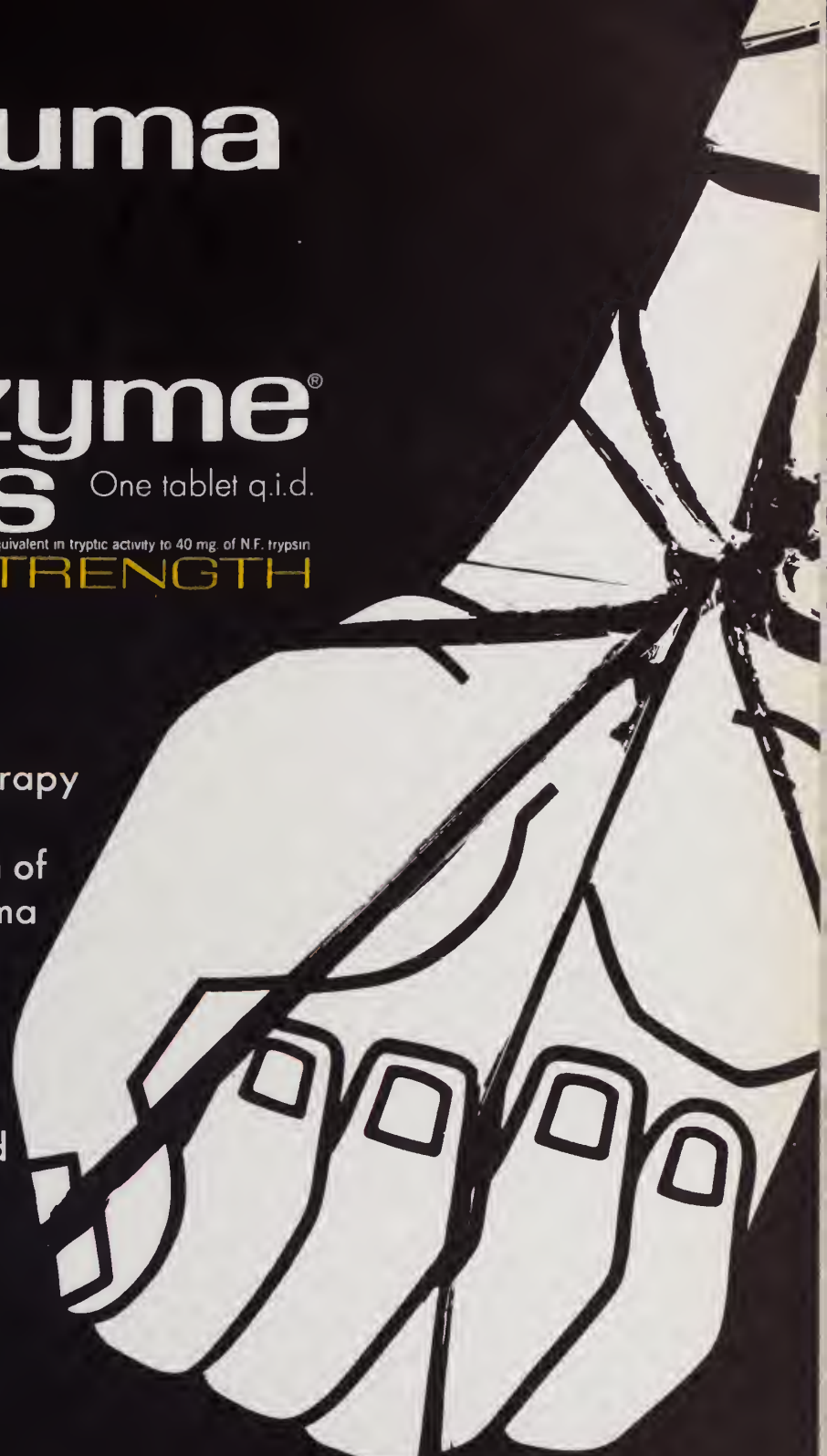
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- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4.'69 0-821A

Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfanamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfanamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfanamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystawsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Ta-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Appraach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. 8., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. 8., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
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PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrachloride 0.2%, sulfanilamide 15.0%, allantain 2.0%)

AVC SUPPOSITORIES (aminacrine hydrachloride 0.014 Gm., sulfanilamide 1.05 Gm., allantain 0.014 Gm.)

TRADEMARK: A V C

AV-919A 7/69



THE INSURANCE PAGE



Management's Views

THIS month the writer wishes to present some of the views expressed by Paul J. Ryder, manager, Benefits and Labor Economics Department, Ford Motor Company.

Mr. Ryder participated in a panel discussion on Future Directions for the Organization of Health Care and their impact on Blue Shield. He presented management's viewpoint at the Blue Shield Annual Program Conference, October 30-31, 1969.

This is not an attempt to completely summarize Mr. Ryder's discussion; only a few of his remarks have been selected and abridged for presentation here.

Never before have so many people been protected through health insurance. Never before have so many medical bills been paid in full. On the other hand, never before has there been so much widespread criticism of and indeed resentment against the health care industry. There is the problem of an ever-accelerating cost of health care. There is the problem of making quality health care available to more people. There is the problem of providing pre-payment mechanisms for a larger portion of the health care services. There is the problem of professional and facility shortages. Indeed there is a demand for complete reorganization of the health care industry—a revolution if you will. The public is demanding more and better medical care, but at the same time demanding a halt to what they consider skyrocketing costs. The group consumer, a new force in health care economics, is insisting that more rigorous cost and performance objectives be met.

Change is in the air and the key to survival in the 70's and beyond for man and his organization is—as in the past—the ability to adapt to change. Resist it and you resist survival.

Mr. Ryder's remarks are meant to be helpful and to be constructive. He quotes from W. S. Gilbert of Operetta fame, "I never read a favorable criticism. I prefer reading unfavorable ones. I know how good I am, but I do not know how bad I am."

Mr. Ryder does not pretend to be able to foretell the future, but he states that one thing can be said about the role of Blue Shield in the private insurance sphere: the future is clouded. It is clouded because group purchaser requirements have become more and more demanding in the face of rising costs and because Blue Shield Plans are faced with increasing competition from other insuring agencies.

Survival in the modern environment lies in the ability to adapt to the cost and performance requirements, which have become increasingly difficult to satisfy.

It is clear that a given package of benefits is going to cost more, not less. The reasons for this have been documented exhaustively. There seems to be no relief in sight. Given this reality, we must seek better ways of providing more benefits for given cost. Thus, in this climate of rising medical costs and increasing demands for more comprehensive coverage, the highest priority should be given to programs which contribute most to lowering total medical costs. We should not be adding new benefits, layer upon layer, but rather we should be designing programs which would contribute to the more efficient practice of medicine. One carrier, who claims to meet the requirement of providing more benefits for a given cost, is that on-going experiment called the group practice arrangement.

Over the five-year period 1960-65, experience under the various federal employe programs indicates hospital use was significantly lower under the group practice plans. Our own experience with the Kaiser Plan indicates that for the same premium or less paid the Blue Shield, employes have, in addition to most Blues benefits, coverage for home and office visits, injectables, allergy testing and treatment, and many other benefits.

Mr. Ryder stated that when he was asked to point out significant Blue Shield Programs or activities which are designed as potential cost controlling devices in the surgical-medical expense areas, he is hard pressed and usually ends up mumbling something about utilization review. This remark was not intended to downgrade the importance and value of utilization review as a technique of achieving better cost and quality control over existing programs. Unfortunately this technique has been used primarily as an auditing and as a fraud control device: Its potential as a cost and quality control technique has not been realized. It is imperative that the full potential of utilization review be developed.

While an understanding public may appreciate the phenomenon of increasing costs for higher quality care, the same public is growing less and less patient with spokesmen of the medical profession who misinterpret suggestions for economic self-discipline as attacks on their professional integrity. He further stated that it behooves Blue Shield management to educate their physicians to the implications of rising costs, and it behooves the physicians to face up to the question of economic responsibility within their own organization. If this is not done, the public trust will have been violated and there is reason to believe the public will look elsewhere for relief. In the last analysis, cost control is in the interest of the doctor as well as the public.

(Continued on page 469)

Summer time...monilia time!

No wonder you see so many more cases of vaginal moniliasis during this season. A damp, warm bathing suit provides a perfect breeding ground for fungal invaders. But your patients need not suffer the pain, the embarrassment and the discomfort of these stubborn infections. Nor the disappointment which comes when they find "the cure didn't take."

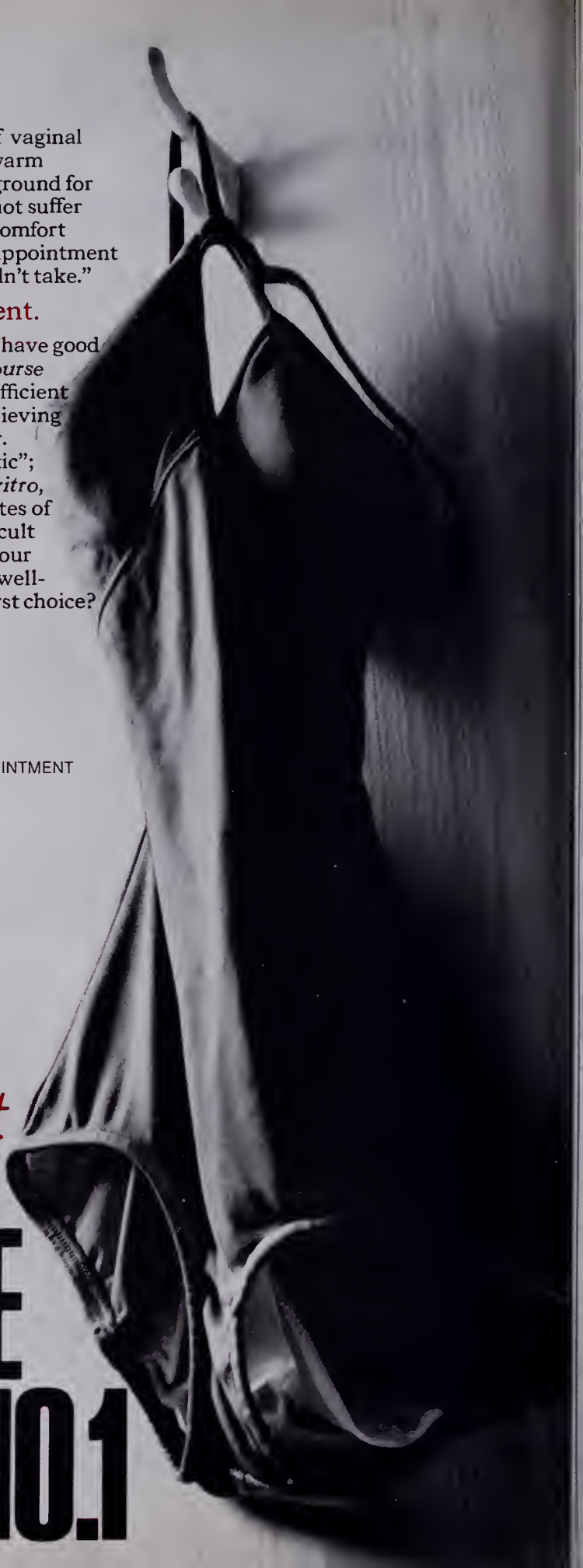
Candeptin avoids disappointment.

With CANDEPTIN, you and your patients have good reason for confidence. *A single, 14-day course of therapy* with CANDEPTIN is usually sufficient to eradicate the invader, while rapidly relieving itching, burning, discharge and malodor. And CANDEPTIN is "cidal" as well as "static"; 100 times more potent than nystatin *in vitro*, it has achieved culture-confirmed cure rates of 90% and more (even in notoriously difficult pregnant patients). Why not maximize your chances of success by adopting effective, well-tolerated CANDEPTIN as your agent of first choice?

Agent of first choice

Candeptin®

candicidin VAGINAL TABLETS/OINTMENT



the fortnight fungicide for

PRIVATE ENEMY NO.1

Candeptin® CANDICIDIN

Formula:
CANDEPTIN Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% candicidin activity in U.S.P. petrolatum. 3 mg. of candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain candicidin powder equivalent to 3 mg. (0.3%) candicidin activity dispersed in starch, lactose and magnesium stearate.

Indications:
Vaginal moniliasis due to Candida albicans and other Candida species.

Contraindications:
Patient sensitivity to any of the components. During pregnancy manual tablet insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution:
Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment or Vaginal Tablets have been extremely rare. To avoid re-infection, it is recommended that the patient refrain from sexual intercourse during treatment or the husband wear a condom.

Dosage:
One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet is inserted high in the vagina, twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Dosage forms:
CANDEPTIN Vaginal Ointment is supplied in 75 gm. tubes with applicator (14-day regimen requires 2 tubes). CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil, with inserter—enough for a full course of treatment. Store under refrigeration.

Federal law prohibits dispensing without prescription. CANDEPTIN is a registered trade-mark of Julius Schmid, Inc.

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PHARMACEUTICALS
New York, N.Y. 10019

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A Link in the Chain

auxiliary

"To extend the aims of the medical profession to all organizations which look to the advancement of health and health education" is a direct quote from the objectives of the Woman's Auxiliary to the Kentucky Medical Association.

All auxiliaries have been encouraged to uphold this concept this year. We have participated in the Rubella program with the State Health Department. We have screened the pre-school children for blindness, a program of the Kentucky Society for the Prevention of Blindness. We have screened grade school boys and girls for kidney disease.

Fayette County Woman's Auxiliary and the Woman's Auxiliary to the Student American Medical Association have worked with the central Kentucky blood center program. Mrs. Donald Edger, Community Service Chairman for Fayette County reports: "The Central Kentucky Blood Center sponsored by the Fayette County Medical Society opened for business October, 1969. The Fayette County Medical Auxiliary volunteered to help in whatever capacity they were needed. A two part program evolved out of numerous meetings: 1. Screening of prospective donors. 2. Blood replacement. A Training program was devised. The volunteers were taught to take donor's pulse, fill out a questionnaire, stick a finger, blood typing and blood pressure. Approximately 95 hours a month are given to the Blood Center.

"In March a second training session was held. The Auxiliary recruited the help of the Woman's Auxiliary to the Student American Medical Association. These women cover the volunteers we have during the two evenings a week the center is open. Two volunteers work at a time, one serving as a receptionist and the other as a screener. The blood replacement center consists of volunteers who visit the patient in the hospitals, talk to him or some member of the family about replacing the blood that has been used. Under the direction of the Fayette County Auxiliary there are 46 volunteers working with the Blood Bank Program."

We are most pleased to report these community service projects to the Kentucky Medical Association.

MRS. HOYT D. GARDNER, PRESIDENT
WOMAN'S AUXILIARY TO KMA

Schering

After only one year:

Administered to more people than live in Lexington, Covington, and Owensboro.*



Injectable Garamycin®

brand of gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Lexington, Covington, and Owensboro is 192,500. (Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections[1,2]

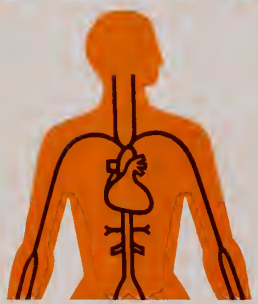
GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Schering

Over 95% gram-negative pathogens sensitive*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains Number of strains tested Antibiotics*							
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
Aerobacter aerogenes	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
Klebsiella aerobacter group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
Klebsiella, all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
Pseudomonas aeruginosa	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
Proteus, indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
Proteus mirabilis, indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
Proteus, unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
Escherichia coli and all other Escherichias	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
Paracolobactrum, all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
Coliform bacteria	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070
Gram-positive (Included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus, coagulase-positive*	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph—*S. aureus, unspecified*	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[8]
Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.
Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.
Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.
It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable Garamycin®

brand of gentamicin sulfate injection

Schering

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover, may result in additive toxicity. Monitoring of vestibular, cochlear and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin in gram-negative urinary and pulmonary infections, Arch. Int. Med. *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., and Smith, J. K.: Gentamicin in the treatment of pulmonary infections, J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a new aminoglycoside antibiotic: Clinical and laboratory studies in urinary tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clinical experience with gentamicin, data from 12 German clinics, in Gentamicin: First International Symposium, Paris, January 1967, Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Laboratory and clinical investigation of gentamicin, *ibid.*, pp. 62-74. (6) Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, H. Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommended in Package Insert.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28 5-02

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

JULY

15 PANMED television series, "Poison Control Center," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

16 Fourth Trustee District Meeting, 6 p.m., Trosino's Restaurant, Lebanon.

22 PANMED television series, "In A Medical Laboratory," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

29 PANMED television series, "Preparation of the Child for the Hospital," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

AUGUST

5 PANMED television series, "Patterns of Nursing II," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

12 PANMED television series, "Detection of Oral Cancer," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

19 PANMED television series, "Family Prescription Records," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

26 PANMED television series, "Football Injuries," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

SEPTEMBER

16-19 Emergency Care and Transportation of Sick and Injured Persons advanced course, University of Kentucky, Lexington

17-19 Postgraduate course, "Pulmonary Function Tests in Management of Chest Disease," University of Kentucky Medical Center, $35 fee.

22-24 Annual Meeting, Kentucky Medical Association, Convention Center, Louisville

OCTOBER

17 Annual Meeting, Kentucky Chapter, American College of Physicians.

NOVEMBER

5-6 Fourth Annual Newborn Symposium, University of Louisville School of Medicine, Louisville.

IN SURROUNDING STATES

SEPTEMBER

10-12 Annual Meeting, American Association of Obstetricians and Gynecologists, Hot Springs, Va.

25-Oct. 1 Annual Meeting, American Academy of General Practice, San Francisco, Calif.

OCTOBER

4 Council on Environmental and Public Health, Roosevelt Hotel, New Orleans, La.

5 Annual Meeting, American Academy of Ophthalmology and Otolaryngology, Dunes Hotel, Las Vegas, Nev.

12-16 Clinical Congress of American College of Surgeons, the Conrad Hilton Hotel, Chicago, Ill.

14-16 Cleveland Course in Pulmonary Disease, St. Luke's Hospital, Cleveland.

25-29 Fall Scientific Assembly, American College of Chest Physicians, Century Plaza Hotel, Los Angeles.

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VOLUME 68 July 1970 No. 7

The Diagnosis of Diabetes Mellitus in Adults†

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Lexington, Kentucky

In making the diagnosis of diabetes mellitus several points obtained on the standard review of systems and physical examination may be suggestive. Methods and criteria for establishing a diagnosis are presented.

DIABETES mellitus is a metabolic syndrome which manifests itself either as a clinical and/or clinical state with hyperglycemia and alterations in lipid and protein metabolism. These abnormalities are generally felt to be secondary to a deficiency of effective insulin production. This definition seems simple enough, yet there are many pitfalls to be aware of regarding the pathophysiology of this disorder and its ultimate diagnosis. Essentially all insulin made available thus far has been extracted from the pancreas and a large number of detailed variations in this procedure has been reported.

Considerable evidence indicates that the major site of synthesis of insulin is in the ribosomes of the beta cells within the islets of Langerhans' in the pancreas[1]. The biosynthesis of insulin in the islet tissue is thought to be similar to protein synthesis elsewhere in the body. However, attempts to correlate insulin synthesis and secretion with a number of biochemical changes has been very difficult and not much progress has been made[2]. A rise in blood sugar concentration triggers beta cell release of insulin. This rise in the insulin level initiates several metabolic events which promote the tissue uptake and storage of glucose, amino-acids and lipids. It is not known for sure why there is a lack of effective insulin in diabetics.

A lot of emphasis has recently been placed on peripheral inhibitors and antagonists which bind insulin. It remains to be shown whether the relative beta cell insufficiency stems from a primary disease or whether beta cell function has been exhausted as a result of a primary excessive demand for insulin due to peripheral insensitivity to insulin[3].

The Importance of the Medical History

There are several symptoms obtained on the standard review of the systems that would at least lead one to suspect a diagnosis of diabetes mellitus. Polyuria, polydipsia, and polyphagia (with or without weight loss) are usually considered the classic triad of the onset of diabetes. Other symptoms suggestive but not specific are: weakness, pruritus (particularly vaginal), nocturia, visual changes, headaches, anorexia, drowsiness, delayed wound healing, recurrent infections and impotence.

Mothers giving a history of the delivery of a nine pound or more baby should particularly be screened for diabetes. It is also important to inquire if the patient has been taking any medications which might tend to increase the blood glucose level. Birth control pills, estrogens, salicylates, nicotinic acid,

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thiazide diuretics, and cortisone-containing medications are several which have been implicated in causing hyperglycemia.

Questions should also be directed towards uncovering any history suggestive of thyroid, menstrual, adrenal, pituitary or previous pancreatic disorders which may be responsible for hyperglycemia. If the patient gives a history of hypertension, consideration must be given to a possible underlying pheochromocytoma which may be accompanied by an elevated blood glucose level. Recent dietary habits as well as stressful situations should be evaluated since starvation decreases insulin production and under stressful situations insulin production may be increased secondary to other hormonal responses. Also recent illness and trauma, as well as inactivity, may decrease glucose tolerance particularly in older patients who are confined to bed for any significant period of time.

It is generally agreed that heredity plays an important role in determining the susceptibility to hyperglycemia so the family history may be of importance from this standpoint. There is widespread disagreement when the nature of the pattern of transmission is discussed. The assumption of a single recessive gene forms a satisfactory working hypothesis but more data are required to establish its validity. On the basis of a simple recessive inheritance all offspring in families with both parents diabetic are generally liable to diabetes. Fifty per cent of the siblings of a diabetic who has one diabetic parent are genetically liable to diabetes and 25 per cent of the siblings of a diabetic whose parents are not diabetic are genetically liable to diabetes.

Value of the Physical Examination

On physical examination it is important to remember that there is an increase in the incidence of obesity, hypertension and vascular problems among the diabetic population. Diabetic retinopathy is a distinct enough pathological entity that it may lead directly to the diagnosis of diabetes. Metabolic cataracts may be found in young individuals and senile cataracts in the older age group. Careful evaluation of the peripheral pulses should be made because of the increased incidence of arteriosclerosis obliterans in diabetics. The deep tendon reflexes along with vibratory and sensory examination should be carefully checked. If the patient appears uremic, or to have chronic underlying kidney disease, diabetic nephropathy needs to be excluded. Examination of the skin may prove diagnostic if necrobiosis lipoidica diabeticorum is present.

Screening and Definitive Laboratory Testing

Since diabetes seems to be related to a relative deficiency of circulating effective insulin, one would assume that a reasonable approach to a diagnosis would be a measurement of plasma insulin concentrations. Although this test is not generally available for clinical use, it has been extensively used as a research procedure. It has been estimated that a normal man probably secretes about 40 to 50 units of insulin daily and with complete destruction of the beta cells usually no insulin can be detected by the diaphragm or immunoassay procedures[4].

Diabetic patients have been found to secrete insulin at normal, hypernormal and subnormal rates depending on the stage of the disease as well as the secretion of other hormones, diet and a number of other factors. Recently, Rimoin[5] reported the mean peak plasma immunoreactive insulin concentrations to be different in two different ethnic groups of diabetics, suggesting that they may represent distinct disorders with ethnic variability of insulin response. Along with the above discrepancies and the minute quantities of insulin in the serum, other factors which need to be considered are the nonsuppressable insulin-like activity, the anti-insulin action of synalbumin and the discovery of pro-insulin by Steiner and co-workers[6]. Considering all of the above as well as a variable response of plasma insulin levels in diabetics subjected to oral glucose loading, it would seem that insulin assays cannot be depended on at the present time for diagnostic purposes.

After the patient has been seen and examined it is often convenient to check a routine urinalysis for sugar and acetone and either a fasting or two hour postprandial blood sugar. Of course, the latter as well as the urinalysis are merely screening procedures that must be followed with more definitive tests if suggestive such as the fasting blood sugar level or an oral glucose tolerance test. In most screening programs using 100 grams

of glucose, values above 140 mgs/100 ml at the two hour level should lead to a strong suspicion of diabetes and values between 110 and 140 mgs/100 ml should probably be followed by an oral glucose tolerance test. A fasting blood sugar of 120 mgs/100 ml or above on at least two separate occasions in a patient who has been eating regularly is generally considered diagnostic in the absence of previous food ingestion or medication on the morning when the sample was obtained.

The oral glucose tolerance test, although criticized by many, remains the most widely used and most important test in the diagnosis of diabetes. Ideally, the patient should ingest 300 grams of carbohydrate and total maintenance calories for at least three days preceding this procedure. The above preparation is necessary to avoid a diabetic curve which may appear in the normal person or so-called "starvation diabetes". Occasionally if not prepared properly, a mild diabetic may produce a non-diabetic type curve. After an adequate preparation, the patient fasts overnight at least for ten hours, has a fasting blood sugar drawn, and then is given 1.75 grams of glucose per kg. (of ideal body weight) or, in most cases, if near the ideal body weight 100 grams of glucose by mouth.

Following this blood specimens, along with urine checks for sugar and acetone, are drawn at one, two, and three hour intervals. The test should begin between 7 a.m. and 9 a.m. because circadian variation in glucose tolerance has been reported and results obtained at times other than the above, would be difficult to compare[7]. The subject should be seated and comfortable during the test, and exercise, caffeine and nicotine should be avoided during the period of testing. There continues to be some variability in the interpretation of test results including the Wilkerson point method, Fajans-Conn criteria and the summation of fasting, one, two and three hour levels. In patients under the age of 50 this author uses the original Fajans-Conn criteria[8] and makes a diagnosis of diabetes mellitus if the one hour level is 160 or greater, one and one-half hour 140 or greater and the two hour level 120 or greater with the auto-analyzer ferricyanide blood determination. For persons above the age of 50, which are presently not well standardized, the Wilkerson point method is used as recommended by the committee on statistics of the American Diabetes Association[9]. Criteria for making the diagnosis with the Wilkerson point method (adjusted for plasma glucose and 40 gm/m^2 glucose load)* is summarized in the following chart:

Time	mg/100 ml	Points
Fasting	130 or more	1
1 hour	195 or more	1/2
2 hour	140 or more	1/2
3 hour	130 or more	1

Two points or more indicate diabetes

The summation of fasting, one, two and three plasma glucose levels have not been used by this author.

There are several modified tests utilizing oral glucose as well as the cortisone preparation glucose tolerance test which are, for the most part, considered research procedures at the present time. Intravenous glucose tolerance testing may be performed in patients with gastrointestinal problems related to the stomach and small bowel and appears to give comparable results to the oral procedure. The intravenous tolbutamide test has likewise been used for diagnostic purposes.

Summary

The present value of insulin assays along with the emphasis of a detailed history and physical examination have been stressed with regard to the diagnosis of diabetes mellitus. Instructions regarding patient preparation for oral glucose tolerance testing and diagnostic values were discussed.

References

1. Williams, R. H., M.D.: *Textbook of Endocrinology*, 1968, pages 614-617. W. B. Saunders Co., Philadelphia.
2. Field, J. F.: Factors Concerned with Insulin Synthesis and Release, *Metabolism* 13:407, 1964.
3. Diabetes Mellitus, Diagnosis and Treatment, American Diabetes Assoc. Vol. II, 1967, pages 1-6.
4. Yalow, R. S. and Berson, S. A.: Immunoassay of Endogenous Plasma in Man, *J. Clin. Invest.* 39: 1157-75, 1960.
5. Rimoin, D. L.: Ethnic Variability in Glucose Tolerance and Insulin Secretion, *Arch Intern. Med.*, Vol. 124, 1969.
6. Steiner, D. F., et al: Insulin Biosynthesis: Evidence for a Precursor, *Science* Vol. 157:697-700, 1967.
7. Bowen, A. J. and Reeves, R. L: Diurnal Variation in Glucose Tolerance, *Arch. Int. Med.* 119:261-4, 1967.
8. Fajans, S. S. and Conn, J. S.: The Early Recognition of Diabetes Mellitus, *Annals N.Y. Acad. Sciences* 82:208-18, 1959.
9. Klimt, C. R., et al: Standardization of the Oral Glucose Tolerance Test, *Diabetes* Vol. 18, No. 5, 1969, pages 299-307.

Tables of height and weight and corresponding dose of glucose are listed by committee. Close approximation can be obtained by using 1 gram of glucose per kg. of actual body weight.

Correlation of SMA 12/60 Biochemical Profile Abnormalities to Health and Disease†

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After accuracy studies of SMA 12/60 instrument, the clinical course of 1500 patients with SMA 12/60 determinations was investigated to determine how often these profiles contributed or confused, and how often did they detect otherwise unsuspected diseases.

THE purpose of the investigation was to determine how SMA 12/60 profiles corresponded to patients' diseases. After SMA 12/60 results were reviewed by a pathologist, they were related to the patients' history, physical findings, hospital progress and other clinical pathology reports to determine how the profile findings supported the clinical conditions with normal and abnormal values. Normal values were just as important in elective surgical, psychosomatic and some other cases as were the abnormal results in many diseases. In addition, otherwise unsuspected diseases or abnormalities and confusing results that were discovered by SMA 12/60 profiles were studied.

Materials and Methods

The first step of this investigation was to determine the accuracy of the SMA 12/60 instrument and to compare this with the accuracy of manual techniques in our laboratory. Hyland unassayed serum (Lot #3651D021A1) was used as the control for the manual and SMA 12/60 determinations. Co-efficient of error and standard deviation were used as parameters for accuracy and precision.

One thousand abnormal and 500 normal SMA 12/60 reports were studied from those consecutive admissions who had such determinations performed. These were correlated with the corresponding patients' records. When it was necessary, the attending physician was contacted for further details. Information was gathered on a card that was designed to contain nearly 70 bits of information on each case. This form adapted easily to key punching for computer analysis (Table 1). The Systematized Nomenclature of Pathology (1965) was used as a basic guideline in the diagnostic classification of the clinical and SMA uncovered diseases. After all data was collected, it was analyzed by IBM 360 Model 40 computer at the Sisters of St. Francis Computer Center in Beech Grove, Indiana.

Results

Accuracy

Accuracy was expressed by standard deviation and co-efficient of error. Ten parameters proved more accurate, glucose about the same, and uric acid less accurate by SMA 12/60 than by manual techniques (Table 2). This accuracy was accomplished by using controls frequently and by repeating any unusual results along with a control. These controls and repeats represented 30+ per cent of the total SMA 12/60 determinations. This was one and one half times the average 20 per cent control rate in our laboratory.

Patients

The distribution of patients according to age, with subdivision into those who had normal and those who had abnormal SMA 12/60 results is shown on Table 3. Women constituted 55.1 per cent and men 44.9 per cent of all patients. This ratio was fairly similar among patients with normal and abnormal biochemical profiles and in the various age groups with non-sex related diseases. The distribution of

†*This work appeared with some modification in the book Advances in Automated Analysis, Vol. III, 1970, published by Mediad.*

**From the department of anatomical and clinical pathology, St. Anthony Hospital, Louisville*

TABLE 1

DATE _____ HOSP. NO. _____ NO. _____

SEX _____ AGE _____ RACE _____ SERV: ☐ GP ☐ INT. MED. ☐ S ☐ OBG ☐ PED

☐ 12/60 NORMAL
- ☐ It should have been normal
- ☐ It should have been abnormal
- ☐ Manual differed from 12/60
- ☐ 12/60 contributed
- ☐ 12/60 confused

☐ 12/60 ABNORMAL
- ☐ Ca ☐ P ☐ GLU ☐ BUN ☐ U.A. ☐ CH ☐ T.P. ☐ AL ☐ BIL ☐ LDH ☐ SGOT ☐ ALK. PHOS.
- ☐ It supported known disease only
- ☐ It uncovered unsuspected disease
  - ☐ of major importance
  - ☐ Subclinical dis s symptoms
  - ☐ of minor importance
  - ☐ unexplained abnormality
- ☐ 12/60 information confusing
  - ☐ Abnormality otherwise proved normal ☐ Repeat Manual Automated Clinical
  - ☐ Normal results otherwise proved abnormal ☐ Repeat Manual Automated Clinical

☐ DIAGNOSIS:
- ☐ CARD.V. ☐ RESP. ☐ DIGES. ☐ G.U. ☐ ENDO ☐ CNS ☐ RES ☐ M-SOFT T.

☐ SMA 12/60 uncovered
☐ SMA 12/60 Dx ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
COMMENT:

TABLE 2

patients according to disease group is listed in Table 4.

Patients with Abnormal SMA 12/60 Profiles

In the survey, two groups of abnormalities were established. In the first group, the clinical conditions were such in nature that they should have had one or more abnormal SMA 12/60 parameters. In cases where good correlation was established between the disease or diseases and the respective SMA 12/60 profile abnormalities, they were recorded as "supported known disease" in the protocol. When such correlation was not clear, or when there was a reasonable conflict between SMA 12/60 results and either the clinical diagnosis or repeated determinations, "12/60 information confusing," was recorded. Of the 1000 patients with abnormal profiles, 577 had such diseases that they should have produced abnormal SMA 12/60 results. (Table 5) In 550 of these 577 cases the profile abnormalities supported their respective diseases, and in 27 they were conflicting. In 25 of these cases, the abnormality proved normal by repeated examination and in only two instances, the conflict could not be solved. In no case was a marked abnormality involved.

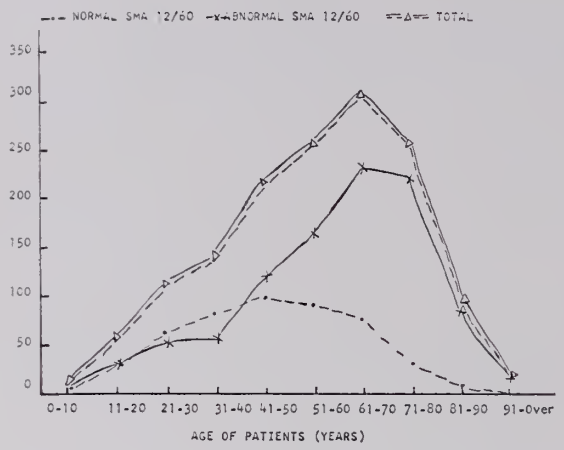
The second group consisted of cases in which there were no clinical or other indications to suspect the results to be outside the normal range. They represented diseases or abnormalities discovered by SMA 12/60 profiling. In some instances these unsuspected

ACCURACY OF BIOCHEMICAL PROFILES BY SMA 12/60 COMPARED WITH MANUAL METHODS

	Mean Value		Coeff. Error		Standard Deviation	
	SMA 12/60	Manual	SMA 12/60	Manual	SMA 12/60	Manual
Ca	8.7 mg%	8.7 mg%	1.725	2.48	.15 mg%	.215 mg%
P	3.7 mg%	3.5 mg%	3.5	8.55	.13 mg%	.3 mg%
Glucose	109 mg%	110 mg%	3.77	3.65	4.1 mg%	4.0 mg%
BUN	11 mg%	11.2 mg%	1.35	2.7	.148 mg%	.3 mg%
Uric Acid	5.3 mg%	5.8 mg%	3.02	2.0	.16 mg%	.116 mg%
Cholesterol	195 mg%	194 mg%	2.47	3.4	4.8 mg%	6.6 mg%
T. Protein	6.15 gm%	6.7 gm%	1.79	3.43	.11 g%	.23 g%
Albumin	3.6 gm%	3.9 gm%	3.17	5.1%	.114 g%	.2 g%
		Mt II				
Bilirubin	.3 mg%	3.7 mg%	2.03	8.1	.061 mg%	.3 mg%
		B-L Units				B-L Units
Alk. Phos.	40 mu/ml	1.25 B&LU	3.75	9.9	1.5 mu/ml	.124
LDH	105 mu/ml	250 Wrb	2.14	4.6	2.25 mu/ml	11.5 Wrb U
SGOT	30 mu/ml	22.5 R&F	.82	1.2	2.46 mu/ml	2.7 R&F U

TABLE 3

AGE DISTRIBUTION OF PATIENTS



cases were present in addition to abnormalities which give laboratory support to already known diseases; in others they were in a group by themselves. These abnormalities were divided into four categories in the protocol (Table 1).

The "uncovered, unsuspected diseases of major importance" were cases with abnormal glucose changes suggestive of diabetes, BUN abnormalities, cholesterol elevations and other results suggesting major diseases. "The subclinical diseases without symptoms" and diseases "of minor importance" were merged into one category because the survey proved their separation arbitrary. Results with minimal abnormalities comprised this group. Unexplained abnormalities included results where neither the clinical situation nor the laboratory experience could account for the value. Some of these findings included decreased LDH levels in young women. These will be studied in detail separately.

There were 429 abnormalities that uncovered unsuspected diseases. The distribution of these is listed in Tables 6 and 7. There were 99 unexplained abnormalities on these profiles.

Patients with Normal SMA 12/60 Profiles

Findings on the 500 patients with normal SMA 12/60 are listed on Table 8. In 493 of the 500 cases, the SMA 12/60 profiles corresponded to the clinical conditions and were normal. In five of the seven conflicting instances, the clinical situation and repeat determinations proved that the normal SMA 12/60 values should have been abnormal. In two cases, the situation still remained somewhat confusing after rechecks.

TABLE 4

DISEASES OF THE SURVEYED 1500 PATIENTS

Disease Group	Patients with Abnormal SMA 12/60	Patients with Normal SMA 12/60	Total
Cardiovascular	264	68	332
Respiratory	189	108	297
Alimentary	275	120	395
Urogenital	175	77	252
Endocrine-Metabolic	106	17	123
Nervous System	72	55	127
Reticuloendothelial	28	7	35
Skin-Soft tissue-Bone	142	89	231
TOTAL	1251	541	1792*

*This figure is excess of 1500 because some patients had more than one disease.

Glucose abnormalities suggestive of diabetes were followed up in 89.2 per cent of cases. BUN abnormalities were followed up in 5.4 per cent of cases.

TABLE 5

CORRELATION OF ABNORMAL SMA 12/60 TO DISEASES THAT SHOULD PRODUCE PROFILE ABNORMALITIES

	NO.	%
TOTAL	577	100.0
Supported	550	95.3
Conflicting	27	4.7
Abnormal Result		
a.) Proved normal	25	4.5
b.) Confusing	2	0.2

Comments

St. Anthony Hospital is a 350-bed, general acute care institution. This determination of accuracy was not only essential in the new instrument but also served as the foundation of the present survey. It provided us with some idea of how SMA 12/60 can perform under "service laboratory battlefield conditions" with proper attendance. The 30+ per cent repeat and control rate with this instrument was a very worthwhile investment in material and work because it provided a high degree of accuracy.

The various patient data were presented to provide an insight into the material.

The profile abnormalities displayed very good correlation and supported the clinically known diseases. In cases where discrepancy was suspected, usually 24 to 48 hours elapsed between the SMA 12/60 report and follow-up. Therefore, some of these cases may have represented true changes instead of conflicting results since the patients were in the hospital and received treatment in that interval.

The incidence of otherwise unsuspected diseases and abnormalities discovered by SMA 12/60 appears high. An unusually large number of BUN elevations and protein or albumin decreases as reflected by the alimentary and urogenital diseases on Table 4 seem to be the major causes of this. Since these changes appeared mostly in the geriatric groups, perhaps widening of the normal ranges should be considered for them.

TABLE 6

DISEASES AND ABNORMALITIES DISCOVERED BY SMA 12/60

	NO.	%
TOTAL	429	28.6*
Major importance	244	56.9**
Minor importance	185	43.1**
Unexplained abnormality	99	

* Of all 1500 surveyed patients
** Of total SMA 12/60 discovered abnormalities

There were many clinically unsuspected diabetics and renal failures that were uncovered by SMA 12/60. Of the diabetics, 89.2 per cent and 94.6 of the renal failure cases were followed up and validated.

One of the cardinal findings of this survey is the excellent correlation of normal SMA 12/60 profiles and their respective diseases. In clinical situations where psychosomatic conditions have to be separated, in pre-surgical and other screenings, SMA 12/60 is very reliable as a diagnostic aid.

A technical problem that surfaced during this survey was the difficulty in scanning the SMA 12/60 reports for abnormalities. The shaded areas showing the normal range are presently staggered and difficult for the eye to follow. It would be much easier to read the report if the scale of normal values were linear in a band form. (Table 9)

TABLE 7

CLASSIFICATION AND INCIDENCE OF DISEASES AND ABNORMALITIES DISCOVERED BY SMA 12/60

DISEASE GROUP	NO.	%
Cardiovascular	28	6.5
Respiratory	3	0.7
Alimentary	96	22.4
Urogenital	177	43.3
Endocrine-Metabolic	143	33.3
Nervous System	1	0.2
Reticuloendothelial	4	0.9
Skin-Soft tissue-Bone	16	3.7
TOTAL	468*	111 *

* This exceeds the 429 patients (100 per cent) because occasionally a patient had more than one such disease.

TABLE 8

CORRELATION OF NORMAL SMA 12/60'S TO DISEASES THAT SHOULD NOT PRODUCE PROFILE ABNORMALITIES

	NO.	%
TOTAL	500	100.0
Supported	493	98.6
Conflicting	7	1.4
Normal Result		
a.) Proved abnormal	5	1.0
b.) Confusing	2	0.4

Conclusions

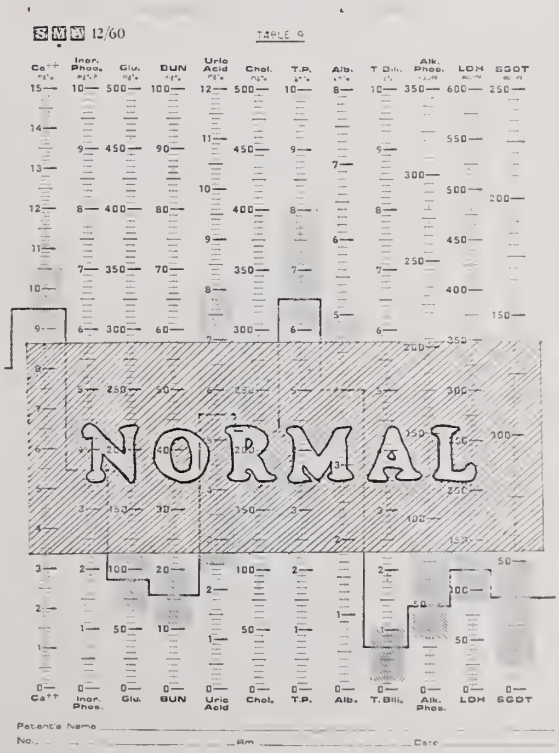
1. SMA 12/60 results were highly accurate provided proper controls were maintained.

2. In diseases where SMA 12/60 determinations should have been abnormal, they were so in 95.3 per cent of the cases.

3. In diseases where SMA 12/60 parameters should have been normal they were so in 98.6 per cent of the cases.

4. Among the conflicting reports in instances there may have been a true change by the time follow-up examinations were performed, therefore, not all these cases should be considered fallacious SMA 12/60 reports.

5. Normal ranges of BUN and serum proteins should be examined and possibly ex-



tended in geriatric age groups.

6. A new report form is proposed that would make the recognition of abnormal results easier.

Appendix

The following list provides useful guidelines for SMA 12/60 report interpretation. It is emphasized that this list is not complete.

	CONDITIONS OFTEN ASSOCIATED WITH:		
	Elevated Values	Decreased Values	Interferring Conditions
Calcium	Hyperparathyroidism Hypervitaminosis D Multiple myeloma Prolonged immobilization Sarcoidosis Metastatic Ca to Bone or other malignancies Leukemia Milk-alkali syndrome Idiopathic hypercalcemia of infancy Hyperthyroidism (rarely)	Hypoparathyroidism Osteomalacia *Acute Pancreatitis* Renal insuff. (P↑) Vit. D. defic. Renal acidosis	Prolonged venous congestion when drawing blood.
Phosphorus	Children (Normal) *Renal insuff.* (Ca) Diabetic Acidosis Hypoparathyroidism Acromegaly Hemolysis	Prim. Hyperparath. Osteomalacia Renal tubular disorder (Fanconi) Certain antacids	Hemolytic blood ↑ ↓ After meal (↑carbohydrate metabolism) ↓ After insulin injection
Glucose	Diabetes Adr. or thyroid Sepsis Tumors Anoxia Nephrosis Diuretics (Thiazide)	Insulin Myxedema Certain tumors Addison disease Liver disease Starvation	Uric Acid I.V. glucose going
BUN 10-20 mg	Renal insuff. G.I. bleeding Urinary tract obstruction ↓ Renal blood flow	Liver dis. Pregnancy ↓ Protein intake	
Uric Acids	Gout Renal failure Toxemia Destruction of cells Chemotherapy Pneumonia Hemolysis Pern. Anemia Medications: Diuretic (Thiazide) Salicylates (Acetazolamide) Hypertension Starvation Violent exercise Diabetic acidosis Ethanol intoxication Psoriasis	Rx with uricosuric drugs	

Cholesterol 150-300	Pregnancy	Liver Disease	↑ Bilirubin
	Nephrotic syndrome Hypothyroidism Hypophysectomy	Hyperthyroidism Tangier dis. (high density lipoprotein deficiency)	↑ Lipemia
	Pancreatitis Diabetes Mellitus Familial cholesterolemia		
Proteins	Alb. Dehydration	Malnutrition Hepatic Renal	↓ 0.4-0.8 gm in supine position
	Glob. Infection	Hypo-gammaglobulinemia	
	Liver disease Malnutrition Mult. myeloma Hypersensitivity Collagen dis.	Agammaglobulinemia Infants Leukemia	
Bilirubin	Neonates Erythroblastosis *Hemolytic anemia* Biliary obstruction Cirrhosis Hepatitis Crigler-Najjar (Cong. non-hem. jaundice) Gilbert dis. (Fam. non-hem. jaundice) Dubin-Johnson (Idiopath. Jaundice)	Not significant	Exposure to light
Alk. Phosph.	*Children* Healing fracture *Bone metastasis* Paget's disease *Hyperparath.* *Biliary obstruction* Liver: Cirrhosis, metastatic tumor, Hepatitis. *Pulmonary infarct.* *Pregnancy*	P.A. Hypophosphatasia	
LDH	Hemolysis M.I. Pulmonary infarct. Leukemia-tumors Dead tissue Brain abscess Grand mal seizure Nicotinic acid Rx. *Not seen in normals* *Indicates disease*		Hemolysis
SGOT	Hemolysis M.I. Cong. failure Dicumerol Rx Trauma Pancreatitis Toxemia of pregnancy		Hemolysis

The Role of Radiation Therapy in the Treatment Of Carcinoma of the Larynx†

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A detailed discussion of laryngeal carcinoma and the reasons for varied approaches to management are presented.

SQUAMOUS cell carcinoma represents over 95 per cent of laryngeal tumors. This paper is concerned with this type of tumor.[1, 2]

The Clinical Staging System for Cancer of the Larynx, American Joint Committee for Cancer Staging and End Result Reporting seems to be widely accepted. This classification is based upon the TNM System proposed by the International Union Against Cancer Committee on Clinical Stage Classification and Applied Statistics.[3] We will follow The American Joint Committee Classification and Staging.

Norris[4] has discussed the problems of classification and staging of cancer of the larynx. A practical classification should not be broken down in an excessive number of groups because of the risk of making some of these groups insignificant. However, if we consider the T2 glottic tumors, under the same category are included superficial tumors involving both cords or one cord with extension to the anterior commissure but with normal mobility of the cord(s) and tumors of one cord or both cords with fixation.

From the radiotherapeutic standpoint the statistics concerning survival will be affected according to the proportion of mobile and fixed cords. It is well known that fixation of the cord(s) is reflected adversely in the curability by radiation therapy. Probably substaging could solve problems like this.

Since Bilroth performed the first total laryngectomy in 1873, and Coutard established the fundamentals of fractionated and protracted radiotherapy, experience has been gained in both surgical and radiation fields.

Radiation therapy and surgery should not be competitive. Good judgment based upon a mutual understanding between the laryngologist and the radiotherapist is basic if we wish to offer the best possibilities of cure for laryngeal cancer.

If the radiotherapists who treat all laryngeal carcinomas with radiation are guilty of poor judgment, the same applies to the surgeons showing an elevated figure of five years survivals at the expenses of performing total laryngectomies in a group of patients whose larynges could have been saved with some conservative operation, radiotherapy or integrated methods.

The radiotherapists have to accept that radical surgery produces a significantly better survival rate. The endeavor of saving a larynx with deep tumor infiltration, edema and fixation or with neck nodes is not justified from the radiotherapeutic standpoint.

The decision concerning surgery or radiotherapy as the only method of treatment should be based, besides associated pathology, upon anatomical location and clinical stage of the tumor. The latter evaluation will be based upon indirect and direct laryngoscopy, lateral x-rays of the larynx and pharynx, planograms and laryngograms.[5, 6, 7]

Each one of the three anatomic regions of the larynx shows tumors with peculiar natural history.

The supraglottic region develops from the primitive pharynx, while the glottic and subglottic regions develop from the superior extremity of the tracheal tube. The tendom of the vocal cords is inserted in an autocatonous tubercle located on the primitive interthyroid lamina. The epiglottis and false cords

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†*Presented at the annual meeting of the Kentucky Chapter, American College of Radiology, September 23, 1969, Louisville*

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arise from the IV branchial arch, the arytenoids and retroarytenoid region from the VI branchial arch. The aryepiglottic folds develop from the IV, V and VI branchial arches. The Tubercle of Santorini derives from the V arch, the segment of the fold anterior to the Tubercle derives from the IV and the part of the fold posterior to the Tubercle from the VI branchial arch.[16]

The embryology of the pharyngo-larynx explains the independent blood and lymphatic circulation of the supraglottic region from the glottic and subglottic regions.

According to Baclesse and Alonso[16] the examination of operative specimens after total laryngectomy for supraglottic tumors show: 1. Tumors of the lower part of the epiglottis or false cord invades both structures. 2. These tumors invade the pre-epiglottic space very early. Posteriorly the extension is to the arytenoid, superficially. Laterally they involve the pharyngo-epiglottic fold, valeculae and base of the tongue. 3. The downward extension is almost always limited just above the anterior commissure. The vocal cords generally remain uninvolved. The ventricle is not commonly affected.

The spread of laryngeal carcinoma based upon serial sections of the organ has been studied by Leroux Robert[17] and Szlezak[18]. Correlation between the gross edge of the tumor and the microscopic infiltration was close in the exophytic tumors. Microscopic infiltration was far beyond the gross tumor edge in the infiltrating tumors. The high mortality was found in the latter group.

The cancers spread mostly in the same anatomical region of origin, but as extension progresses, other anatomical regions can be involved. Tumors of the vocal cords extend to the anterior commissure and opposite cord, ventricle or subglottis. Subglottic tumors extend primarily downward, the upper limit is most commonly the vocal cord. Supraglottic extension is not common.

Tumors of the supraglottic region could involve the subglottis through the anterior commissure, so called transglottic tumors, or through the posterior commissure in tumors of the posterior part of the false cord. When tumors of the subglottis involve the supraglottic region, the spread is through these same pathways but in opposite directions.

Ossification of hyaline cartilage facilitates tumor infiltration.

The incidence of metastatic nodes when the three regions of the larynx are considered together is about 30 per cent.[12, 19, 20, 21, 22]

If the presence of nodes is broken down in relation to the anatomical region where the primary laryngeal tumor originated, the supraglottic region shows the highest incidence of metastasis. Norris[19] shows 29 per cent metastatic nodes in patients without palpable neck nodes; the percentage increases to 40 per cent when the aryepiglottic fold or arytenoids are involved. McGavran et al[20] point out the high incidence of metastasis in tumors of the supraglottic region. Also, they show that transglottic tumors presented unilateral nodes in 50 per cent of their cases and 50 per cent of this group with metastasis had bilateral metastasis.

Subglottic tumors are expected to produce metastasis in about 30 per cent of patients.[22] Glottic tumors show the lowest incidence of metastatic nodes in early stages of the disease.

With a better knowledge of the natural history of laryngeal carcinomas based upon the previous known facts as well as a significant reduction in radiation complications due to an understanding of time—dose—volume relationship,[9, 12] radiation therapy has been used alone and combined with surgery, chemotherapy and oxygen in the treatment of laryngeal carcinomas.

Glottic Tumors

Stage I glottic tumors treated with radiation therapy offer a five year survival rate of 71 to 91 per cent.[1, 8, 9, 10, 12, 13, 14, 15, 22, 23] Laryngofissure and cordectomy offer comparable life expectancy. The decision between radiation therapy and cordectomy should be based though, on factors other than survival expectancy. The peculiar anatomical and biological characteristics render this tumor treatable and curable through small field size with doses of 5000 rads to 6000 rads in five to six weeks respectively when Cobalt 60 irradiation is used.

The quality of the voice is probably the determining factor between surgery and radiation therapy. With the small volume and fractionated dose, good quality voice should be ob-

tained in about 85 per cent of treated patients, 10 per cent are expected to have a useful voice. Laryngeal edema or chondronecrosis requiring tracheostomy or laryngectomy is a rare complication.[8, 9, 12, 13]

Stage II glottic tumors should be individualized and two subgroups considered from the radiotherapeutic standpoint. One of the subgroups, represented by tumors involving superficially both cords with normal mobility, offer an expected five year survival of approximately 60 per cent.[12, 24, 14, 15]

The other subgroup to be considered is the Stage II but with fixation of one or both cords.

It is obvious that between normal mobility and complete fixation of the cord(s) several degrees of impaired mobility do exist.

Lack of mobility is an expression of tumor infiltration of the vocal muscle. Frequently the thyroarytenoid muscle is also involved and through it, the tumor becomes fixed to the perichondrium of the thyroid cartilage, anteriorly.

Stage II glottic tumors still show a low incidence of metastatic nodes [10,12,22] and are amenable to be included in a small, parallel opposing field technique. The usual dose is 6000 to 7000 rads in six or seven weeks when Cobalt 60 radiation is used.

As far as tumors of the glottis are concerned, besides the infrequent patient with neck nodes, the second factor determining the choice between surgery and radiotherapy is infiltration. Fixation of cord(s) reduces five year survival to about 30 per cent.[12, 13, 14, 15] Surgery should be the first choice in these cases.

However, in several centers, patients with Stage II glottic tumors with fixed cord(s) are treated with radiation at least initially, until a dose of 4000 to 5000 rads is reached and then according to tumor response, further radiation or total laryngectomy is utilized.

The evaluation is rather difficult when the decision has been full radiation therapy treatment. Recovery of normal mobility during the last part of a 6000—7000 rad six to seven week plan is seen in a proportion of cases. Mostly these are patients without complete fixation.

When the cord(s) are completely fixed it is not common to regain mobility during or at completion of the same dose time. As a matter of fact, some cases will survive five years or longer with a fixed cord(s).

The follow-up examination of patients whose larynges have not recovered mobility is difficult to evaluate, even more if associated with edema. The indirect laryngoscopy or the direct laryngoscopy does not reflect the true situation.[26]

On the other hand, laryngeal edema could produce fixation of the cord(s). The diagnostic problem could be again formidable. We know that the complications and recurrences in the larynx occur mostly during the first year after radiation treatment. Tracheostomy, antibiotics and close examination could be offered in cases with negative biopsy. Some of the patients without microscopic diagnosis and persistent edema should have total laryngectomy.

The policy of treating Stage II glottic tumors, with cord (s), fixation by radiation in an attempt to save the larynx is supported, to a certain extent, by the 65 per cent cure rate achieved by total laryngectomy in radiation therapy failures.[10, 15, 27, 28]

Stage III & IV glottic tumors do not offer a decent five year survival expectancy when treated with radiotherapy.[9, 10, 11 12, 14, 15, 22, 25] The presence of lymph nodes and extensive local disease render these patients poor candidates for radiation therapy. Total laryngectomy with therapeutic neck dissection offers a better prospect, although poor, than radiotherapy.

Supraglottic Tumors

We have seen the high incidence of metastatic nodes produced by tumors of this region and we know the poor control rate on these nodes when treated with radiation therapy. Stage I and Stage II superficial lesions are highly curable with radiation therapy. Robbins[29] reports 70 to 80 per cent five year survival in early lesions. Ennvayer and Bataini[30] also report satisfactory results in early lesions. Wang and Schultz report 48 per cent five year survival in Stage III supraglottic tumors.[15] Their patients are staged according to Nielsen and Strandberg classification.

Stage III and Stage IV show a low cure rate by radiotherapy. Surgery is the treatment of choice.

The cure rate of the supraglottic region is the lowest of the three anatomical regions of

the larynx. Lymph node metastasis and cartilage infiltration are the two contributing factors for the poor five year survival.

Subglottic Tumors

Subglottic tumors are generally considered for surgical treatment. Lampe[31] and Baclesse[12] published results of radiation treatments which are poor. Lederman[32] reported 36 per cent five years survival of 42 patients treated with radiation. We would not hesitate to irradiate exophytic, Stage I lesions for curative purposes.

Integrated Methods

The uniform poor results obtained in Stages III and IV in any of the three anatomical regions of the larynx when either surgery or radiation therapy has been used alone have been the basis for combined methods of treatments. Different sequences have been used in accordance with better knowledge of the radiobiological principles.

(a) *Post-operative Radiotherapy*: The objections for this sequence of combined procedure are: (1) Cutting across peripheral extensions of the tumor, (2) Opening of lymphatic channels, perineural lymphatics and fascial planes which together with surgical manipulations are considered an important factor in spreading and implanting cancer cells, (3) Producing scar tissue in the tumor bed with subsequent reduced blood and oxygen supply rendering the neoplastic cells less responsive to radiation.

However, Leroux Robert [17, 33] and Leroux Robert and Ennvayer [34] observed better survival in supraglottic tumors when radiotherapy was used post-operatively.

Baclesse [36] reported 50 per cent five year survival for 59 patients with advanced carcinoma without neck nodes when laryngectomy was followed by radiotherapy.

McComb and Fletcher[35] used radiotherapy after total laryngectomy with or without neck dissection for supraglottic tumors when residual disease was suspected. In a group of 42 patients, 18 having proved metastatic lymph nodes, 18 received post-operative radiotherapy. Five of 16 patients have survived five years; 11 of 24 have survived three years.

Currently, with the understandable objections, post-operative radiotherapy is used when residual disease is known to remain or when an inadequate surgical-margin is suspected. Inadequate margin of dissection of lymph nodes with adhesions to the carotid sheath or at the upper part of the jugular chain, infiltration of the pre-epiglottic space, and extensive subglottic tumors are examples of surgical procedures in which post-operative radiotherapy could be indicated. The basic dose is 6000 rads in six weeks through generous field sizes. Irradiation should be started after adequate healing of the surgical wound. Radiotherapy used under such circumstances could be considered a therapeutic procedure with reduced possibilities of success. The demand for post-operative irradiation increases with the liberality of the operative indications.

(b) *Pre-operative Irradiation*: Radiobiological principles: (1) Irradiation of mammalian cells *in vivo* and *in vitro* have a common response of a population of cells to irradiation. The relation between the fraction of survival cells and the radiation dose approximates an exponential function. From this observation clinically significant interpretations and extrapolations can be deduced. [37, 38] All the studied cells are sensitive to radiation; the sensitivity of normal and tumor cells is the same within narrow margins. A small dose of radiation (500 to 1000 rads) inactivates the majority of cells but complete inactivation and cure of a tumor requires large dose (between 3000 and 6000 rads).

(2) The growing peripheral part of a tumor has a vascularized stroma and adequate oxygen supply. The core of the tumor is under hypoxic conditions. The radiation inactivation of cells is more effective at the growing peripheral part than at the core of a tumor.

The theoretical advantages of pre-operative radiation are based upon the above principles. Surgical failures are expected to be reduced because the possibilities of dissemination of tumor cells into the wound area from spilled cells are less. The local recurrences secondary to cuts across the tumor extensions are expected to be reduced. Excision of the tumor core, where poorly oxygenated neoplastic cells form the nidus so often responsible for local recurrences, is expected to reduce radiation failures.

Indications of Pre-operative Radiation and Theoretical Advantages

Pre-operative radiotherapy is indicated in the group of laryngeal tumors offering the high rate of local failures and metastatic nodes. The most important factors concerning prognosis in laryngeal carcinoma is lymph node involvement followed by the anatomical stage of the disease. Stage III and IV supraglottic tumors fulfill both factors. Consequently, pre-operative radiation is expected to improve the cure rate in advanced supraglottic carcinomas. It is possible that pre-operative irradiation could reduce local recurrences around the tracheostomy in Stage IV glottic and subglottic tumors. The general theoretical advantages regarding pre-operative irradiation according to Bloedorn[39] are: (1) reduction of the local extensions of the primary tumor, (2) control of lymph node metastasis, (3) decreased possibility of local seeding, and (4) reduced production of distant metastasis.

Some of the enumerated advantages of pre-operative irradiation of laryngeal carcinomas have been proved on a clinical basis. Advantages #1 and #3 have been proved as well as advantage #2.[40, 41] Advantage #4 is very difficult to prove.

Dosage, Complications and Results

Revision of the doses administered pre-operatively in carcinoma of the larynx could be grouped in two categories: small dose of the order of 2000 to 3000 rads over a one to three week period[42, 44, 41] and large doses of the order of 5500 rads in a five weeks period.[43, 26] Cobalt 60 is the quality of radiation mostly used. The elapsed period between radiation therapy and laryngectomy has been about three weeks for small doses and between three and six weeks for larger doses.

The value of pre-operative radiation seems to be significant in Stage III and IV supraglottic laryngeal carcinomas.[43, 44, 45, 46] The apparent unproved results are reflected in a decreased incidence of recurrence locally in neck nodes.[40, 41, 43, 47, 48] However, available clinical studies provide no definite conclusions on the survival results.

Conclusion

Radiotherapy is an excellent tool in the management of superficial carcinoma of the larynx. Radiocurability of laryngeal carcinomas is limited by the presence of nodes and by local infiltration. According to randomized series, local and neck recurrences are reduced when preoperative radiation therapy is used in advanced stages of the disease.

References

1. Smith, R. R., Caulk, R. M., Russell, W. O., Jackson, C. L.: End Results in 600 Laryngeal Cancers Using the American Joint Committee Proposed Method of Stage Classification and End Results Reporting, *Surg. Gyn. Obst.*, 113 435:1961.
2. Clinical Staging System for Cancer of the Larynx. American Joint Committee, June, 1962.
3. Union International Contre le Cancer, 1958.
4. Norris, C. M.—Problems in Classification and Staging of Cancer of the Larynx. *Ann. Otol.* 72: 83: 1963.
5. Holtz, S., Powers, W. E., McGavran, M. H., Ogura, J. Contrast Examination of the Larynx and Pharynx. *Am. J. Roentgenol. Rad. Therapy and Nuclear Med.*, 89: 10-28: 1963.
6. Klein, R., Fletcher, G. H.: Evaluation of Clinical Usefulness of Radiological Findings in Squamous Cell Carcinoma of the Larynx, *Am. J. Roentgen.* 92:43:1964.
7. Lehman, Q. H., Fletcher, G. H.: Contributions of the Laryngogram to the Management of Malignant Laryngeal Tumors, *Radiology*, 83: 486: 1964.

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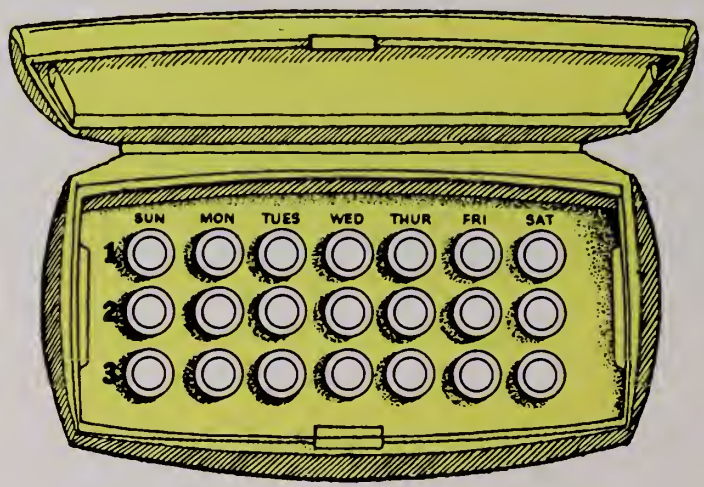
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Warnings—The physician should be alert to the earliest manifestations of rombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary mbolism and retinal thrombosis). Should any of these occur or be suspected e drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies morbidity in the United States have shown a statistically significant associaon between thrombophlebitis, pulmonary embolism, and cerebral thrombosis nd embolism and the use of oral contraceptives. There have been three princiil studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The timate of the relative risk of thromboembolism in the study by Vessey and oll[3] was about sevenfold, while Sartwell and associates[4] in the United States und a relative risk of 4.4, meaning that the users are several times as likely to ndergo thromboembolic disease without evident cause as nonusers. The merican study also indicated that the risk did not persist after discontinuation administration, and that it was not enhanced by long-continued administraon. The American study was not designed to evaluate a difference between oducts. However, the study suggested that there might be an increased risk of romboembolic disease in users of sequential products. This risk cannot be uantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or mplete loss of vision, or if there is a sudden onset of proptosis, diplopia or igraine. If examination reveals papilledema or retinal vascular lesions medicaon should be withdrawn.

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A small fraction of the hormonal agents in oral contraceptives has been ideied in the milk of mothers receiving these drugs. The long-range effect to the rsing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should inude special reference to the breasts and pelvic organs, including a Papanicoou smear, since estrogens have been known to produce tumors, some of them alignant, in five species of subprimate animals. Endocrine and possibly liver nction tests may be affected by treatment with Demulen. Therefore, if such sts are abnormal in a patient taking Demulen, it is recommended that they repeated after the drug has been withdrawn for two months. Under the inience of progestogen-estrogen preparations preexisting uterine fibromyomas ay increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

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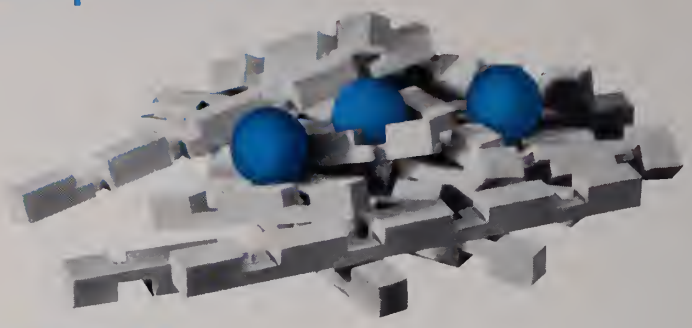
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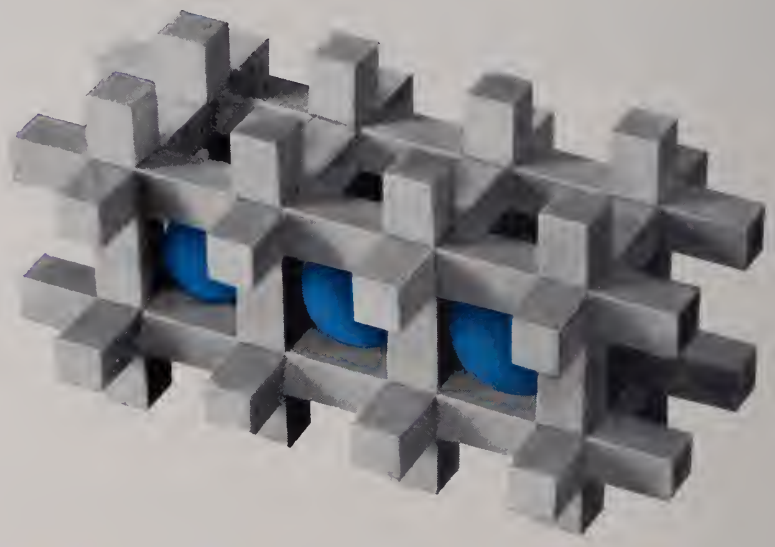
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Blue Cross-Blue Shield in Kentucky—Today

J. Ed McConnell*

I APPRECIATE very much this invitation to be on your program to talk about Blue Cross and Blue Shield in Kentucky today. I have been asked to tell you who we are, and where we are today, attempt to answer some of the questions that are most asked by doctors about the programs, and relate to you some of the major concerns members have. One very important function we play is a feedback role from the consumers to providers. Also, I want to comment on our role in the future, as I see it.

Blue Shield is a non-profit prepayment plan for surgical-medical protection, organized by the medical profession for people, to help them budget in advance for better health care for themselves and their families and be in a better position to meet their responsibilities to their doctors. Blue Cross was organized by hospitals in Louisville, Kentucky, at the request of the Jefferson County Medical Society, to help people have better health care and to budget in advance for hospital care.

We operate very differently from an insurance company. We have a different purpose and objective. This is no reflection on legitimate insurance companies. Our income goes for benefits. We pay no commissions; no dividends; no directors fees. Members of our boards serve without pay as a public service. Our employees work for salaries, no commissions or stock options.

One by-product of Blue Cross and Blue Shield has been to cause insurance companies to try to operate more as we do, to improve their operations, increase benefits, cut costs, to offer their members similar privileges that Blue Shield members are eligible for, and more are trying to do so.

Should Blue Cross and Blue Shield be removed from the picture, we know insurance rates would increase, benefits would decrease, underwriting would toughen. We are the conscience of the prepayment industry.

The concept of Blue Shield as a resource for medicine, as well as for the public is fundamental to an understanding of what Blue Shield is all about. Medicine and Blue Shield and Blue Cross Plans need the support of the consumer, his knowledge, his experience, his expertise, his capacity to play useful roles in the system. We need allies. Medicine needs the resource of Blue Shield and Blue Cross to help cope with today's problems. We are not organized as a commercial insurance carrier. We don't do business in their way; we are committed absolutely to a partnership approach with medicine and to the problems of health care financing. There are many basic differences between Blue Shield and the commercial carriers, many of whom provide excellent coverage, one of which is the professional relationship we have with medicine. We believe that the public interest is best served by including a determination of local medical policy and its organizations through cooperation and support. Local autonomy and local relationship are one of our greatest assets; also, our tie-in with the national Blue Shield organization is an invaluable asset to medicine because Kentucky is a branch office, branch plant state, and policies that are made in many states, or benefits that are purchased, could affect us.

We, both Blue Shield and Blue Cross, work very closely with the Kentucky Medical Association and always try to observe their policies and wishes and work as a team with them. Policies are set by the Blue Shield Board, of which 75 per cent are doctors, and medical decisions for both Blue Cross and Blue Shield are made by doctors, not non-medical people.

Blue Cross and Blue Shield are aligned with social goals. We are quasi-public institutions whose purpose has always been to serve the public interest. We are fighting for a cause and a way of life. We are one of the bulwarks of what remains of our free enterprise system, and we are a product of the free enterprise system.

Your profession has organized a plan for people, controlled by doctors, that, if properly managed, promoted and protected, may help keep much of the economic control of medicine in the hands of the medical profession, and doctors may well soon, as Doctor Roth said last night, if not astute, lose this control, which is a very serious responsibility and a trust.

Blue Shield has provided the medical profession with an intelligently coordinated and professionally controlled corporate body through which the profession and public may deal effectively in their common interest and to their mutual benefit. All of this,

Presented at the 1970 KMA Interim Meeting, April 9, Kentucky Dam Village State Park, Gilbertsville by J. Ed McConnell, president of Kentucky Physicians Mutual, Inc. and the Blue Cross Hospital Plan, Inc.

though, requires understanding, knowledge, management and communication.

Now, as to where we are—last year, in Kentucky, we paid about $125,000,000 for services. This year the amount will approach almost $140,000,000. About $59,000,000 of this was for contracts that were administered as a fiscal intermediary for the government; that is, Part A of Medicare and CHAMPUS. The balance was from the private sector. We have enrolled in Kentucky over 11,500 firms and organizations who are making our protection available to their people on a group basis. The Kentucky Farm Bureau, a fine ally, offers protection to their members; we have about 300,000 members on a non-group basis; that is, subscribers who make direct payments to our office. Blue Cross membership in Kentucky is over 1,110,000, and Blue Shield 1,050,000. These members have various levels of protection that are not uniform by any means, as Blue Cross and Blue Shield are voluntary; some of these benefits are determined by labor-management contracts; others are selected by the employees and by management, and those on a direct basis are eligible to select various levels of benefits. Kentucky is a low per capita income state, and it would be impossible to have only one level of benefits available to the people of Kentucky. We receive 3,750 claims daily, of which 84 per cent are routinely processed. All are paid in about seven to ten days. We have some claims where there is a problem of identifying the member or determining the service that was provided. We have to then request additional information. We cannot approve about nine per cent of claims that we receive, which is very low. We don't like to reject any claims, but if we paid every claim that we received, some of us might wind up in the penitentiary. We would at the very least be guilty of malfeasance or mismanagement. We receive claims that are filed for benefits that people are not eligible for, or paying dues for, claims on contracts that are no longer in effect, and also we have to reject some claims because of pre-existing conditions. For example, there is a nine-month waiting period for maternity protection under most of our contracts, and a 12-month waiting period on many for pre-existing conditions.

All contracts have certain legal limitations which are filed with and approved by the Department of Insurance. They are rated and dues are paid in accordance with the benefits provided, and they must be administered in compliance with law. We have, unfortunately, some members who have the lowest possible benefits they can buy. We cannot force these people to upgrade this protection, although we constantly try to get them to do so. Neither can we cancel them because we know they have protection that is inadequate. These programs are voluntary and some can't increase their protection because they don't have the money to pay for it. Many feel that they are better off to have a minimum amount of protection because, unfortunately, they think charges are increased to people because they have protection. Some don't get concerned about better protection, completely ignore everything you tell them, until such time as they anticipate a case, and then it becomes awfully important to them to try to upgrade. It's too late then to allow it.

I am very pleased to tell you that on both corporations our overhead operation ranks among the lowest in America. Kentucky Blue Cross has the lowest cost per subscriber contract, which is .455, of all the Plans in America with over a million members; and Kentucky Blue Shield has the second lowest cost per subscriber contract of all Blue Shield Plans in America, which is .470.

We have 525 employees, many highly motivated and dedicated, and a number who could do a lot better financially in other businesses.

Our daily mail load is over 11,500 pieces; almost 3,000,000 pieces a year.

Among the questions most often asked us by doctors, one is, "Why doesn't Blue Shield and Blue Cross provide more out-of-hospital and diagnostic protection?" We can and do provide diagnostic benefits out-of-hospitals; however, we can't force the people to buy it. More will have it now that Usual and Customary Programs are available. Incidentally, when a group of people are willing to pay the much higher dues necessary for this protection, it is a positive vote of confidence, by laying cash on the line every month, in doctors and Blue Shield, and this is another reason why peer review is so important. If they lose this confidence, they will turn to their legislators, just as they did this year to get a law passed regarding the medical schools. Diagnostic and out-patient protection costs additional dues which the member has to pay. There are more services used by people, more delivered, and this will increase the overall cost of care. A very widely held and apparently logical supposition that to lower the cost of medical care is to broaden prepayment coverage to provide out-patient coverage. The assumption here is that with more out-patient benefits, the subscriber who normally would become in-patient would take advantage of the benefits and become out-patient and thus free hospital beds and lighten the workload of the hospitals. A study of out-patient benefits has just recently been completed by Kansas Blue Cross and Blue Shield Plans that shows that when the theory is put into practice, apparently it doesn't work this way. They conducted an eight-month study and found that when the experimental group was offered comprehensive out-patient benefits, there was no change or saving on hospital in-patient use. To answer the question, though, we can and do offer diagnostic out-patient protection; however, members have to pay additional dues for it.

We are also asked, "Why don't you provide, in an effort to bring the cost of care down under all of your contracts, nursing home or extended benefit protection?" We do offer our members an opportunity to buy protection that will pay for benefits in extended care or nursing homes; however, this, too, requires additional dues, and we can't force anyone to take it. I am very pleased to advise you that we now have almost 400,000 people in Kentucky with such protection.

I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties

Contraindications. History of sensitivity to meprobamate

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient, if persistent and associated with ataxia, usually responds to dose reduction, occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

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Another question that is often asked by doctors is, "How do you tell members what benefits they are eligible for and what they are not eligible for?" This is a real problem in communication. We, by policy, have our people undersell the benefits that people are eligible for. We have our descriptive literature describe in blue the benefits that members are eligible for, and the exclusions in red. We also, in the certificates of membership, spell out exactly what benefits they are eligible for and what they are not eligible for. Our enrollment men never get the opportunity to talk directly to more of our members. Most companies do their own enrolling, especially new employees. We never see the dependents. Non-group applicants apply, for the most part, by mail, and Farm Bureau agents enroll their people. Unfortunately, many people just don't want to believe what they read in a contract or what they hear. This is a tough problem that we are constantly working on.

In connection with questions regarding additional benefits, it must be remembered that these programs are voluntary. People pay for this protection out of their income or savings or take it in lieu of wages. We cannot force anyone to join; we can't force them to upgrade their protection, and we don't want this authority. This would be compulsion, which we do not believe in, and which we are fighting. Compulsion breeds compulsion. To get people to buy and to upgrade their protection and also to keep it is a constant matter of education, of promotion, of salesmanship, of leadership, and of giving service and having satisfied members.

Now regarding some of the concerns of members. I would say that the number one question we are asked and the number one problem that they are concerned about is the constant increase in the cost of care and asking if it is justified and if there is much unnecessary utilization. We are daily asked about the cost of hospital care, and about doctors' charges. We attempt to answer these questions and reassure people that they are not being abused and to do a public relations job for hospitals and doctors.

In regard to hospital costs and the reason for it, hospitals have not done a very good job in explaining their problems to the public, even to some medical staffs. Few people realize, for example, that it takes on the average of 2½ employees per patient to operate a hospital, that hospital care is a personal service, and a hospital can't be automated like a factory; that about 70 per cent of a hospital's cost is for salaries, and that hospital employees are still among the lowest paid in the nation. Unions are now being successful in organizing some hospitals. When Johns Hopkins was organized, the contract required an increase of $18.00 per day for care.

Hospitals are facing some real problems. On March 25, the Maryland legislature passed a bill that would make Maryland another state to regulate hospital rates. The bill provides that after July 1, 1971, licenses would be issued or renewed only for those hospitals that show they are "rendering services at reasonable charges to the public." Hospitals and other health care facilities would be required to furnish their financial records to a state agency, which would determine whether their charges are reasonable. The agency would be given subpoena power to obtain financial records from institutions refusing to produce them.

The state will also regulate the number of health facilities in an area to insure that needs are met. The Pennsylvania legislature just had a bill introduced that the headlines say would regulate everything but the patient's pain.

This type of control, at the state level, could spread, and many business people as well as labor leaders, and the public in general, unfortunately, will support it. I'm sure pleased that nothing like this was introduced in the Kentucky legislature, and I hope none is in the next.

We are daily asked if doctors increase their charges because a person is a Blue Shield member or has an insurance contract. We attempt to assure them that we feel there is very little of this; that charges are made on the basis of services rendered, and no one should be penalized by higher charges because he is trying to budget in advance to meet his responsibility to his doctor; if this were done much, it would destroy prepayment, because if people felt they could have lower charges if they did not have protection, few would carry any. We also tell them what you are now doing in peer review, which, gentlemen, may be the mechanism to keep much of the economic control of medicine in the hands of doctors.

People are concerned about utilization, and we are asked if there is much abuse. We tell them about utilization committees, locally and for the state, and about tissue committees.

In regard to hospital utilization, if the average length of stay in Kentucky hospitals could have been reduced last year by one-half day, there would have been a saving to our members of 3½ million dollars, and to Medicare of 2½ million dollars.

We are very much aware of the pressure that you are put under by patients to admit them to a hospital, simply because they have Blue Cross or a prepayment plan, for services that might be rendered out of hospital. In regard to the cost of care, we recently, on a national account that has a large plant in Kentucky (many of you are customers of this company and many of you have patients who are employees of this company) had to deliver a national rate increase to them of $30,000,000. This company has a union leader that is very active in promoting a national compulsory health plan. So far, he has not had the support of the companies that he bargains with in this matter, but with increased costs like this, if they felt that they could spread the cost by taxes over the entire public and cut their cost, they might take an entirely different approach. He now claims an understanding with some of them on compulsory health protection.

I'm often asked, "What about Blue Cross and Blue Shield, as well as commercial insurance, in the event of a national compulsory health program?" I said in

Chicago a few weeks ago, in a speech for the American Medical Association, that in my opinion we do not need in America a national compulsory health plan. We need flexibility and free choice in health that must be protected, and encouraged. These are roles that we play in Blue Shield and Blue Cross. Compulsory health insurance won't solve today's health problems and won't reduce the cost of care. It won't increase the capacity of the health profession or the hospitals to deliver service. It won't improve the distribution of health professionals, nor will it make an adequate spectrum of health care accessible to the indigent; on the contrary, it could compound these problems. What the people in Kentucky want is access to their own family doctors.

I'm really not too pessimistic about the future and our role in it. I see hope and perhaps new and greater opportunities, which, though, will require knowledge, thought, planning, action and much work. The job of trying to solve our problems in the health field, as well as our social problems, is so big it can't possibly be done by government alone. The private sector is now deeply involved, and we have got to get even more so; there has got to be more voluntary dollars, efforts, leadership flowing into the health care system, not less. A vital part that Blue Cross and Blue Shield play in this is, of course, financing, plus helping identify public needs and wants, and serving, as I said earlier, in a feedback role to not only doctors but to hospitals. The public is not going to be satisfied with just what the government might feel is adequate or what it might be able to pay for, regardless of how ambitious government plans are. Also, many companies are almost in revolt over payroll taxes.

One very important role that we play, is the rapport and understanding we have with people and providers at the local level that the government does not have and cannot develop. Our system was designed for people, not the people for the system. The role that we play in communication with the people and providers regarding voluntary prepayment as well as Medicare benefits is not probably as much understood and appreciated, but it is very important. We play a psychosocial role that is badly needed by many people, especially those over 65, even when they are not hospitalized. Many are anxious, doubtful and distrustful about dealing with the unknown and people or organizations they don't know. They flood us with questions about benefits and claims.

We in Blue Shield and Blue Cross are going to become even more aggressive in promoting and selling other benefits such as out-patient protection, nursing home care, home health care, preventive care, dental care, even trying to fill a void of custodial care which is a serious problem; encourage the use of least expensive alternatives. To effectively do so, though, is going to require a knowledge on the part of people and providers, a willingness to pay for it, more and better utilization and peer review committees. We have got to find ways to decrease paperwork and claims, provide direct access on claims to computers.

Last fall an official of the Ford Motor Company, speaking on health at a conference in San Francisco, said, "A key to survival in the 70's and beyond for man and his organization is, as in the past, an ability to adapt to change; resist it and you resist survival." It is very evident that in the 60's there has been a rapid change in the mood of this country. We know that in the business we are in, there is going to be change; there has been a lot of change. There will be more.

In a meeting the other day in Washington, a luncheon meeting that was arranged for a group from Louisville with Gerald Ford, the Minority Leader of the House, I asked him if he thinks that we are going to be saddled with a national compulsory health program in this country within the next few years. He replied, "What do you mean the next few years?" I said fifteen. He said, "I was going to say, not within the next decade provided these two things happen: (1) that we keep the right people in Congress, and (2) the private sector comes up with some better answers."

The real issue we now face, in my opinion, more than that of health care is, can a free people organize in a responsible way to solve problems, or whether we continue to move step by step into the grip of an all-powerful government.

Many of the answers to some of the problems of health care delivery and cost are now pretty apparent. The question is, will our voluntary system rise to the occasion and give leadership in solving as many of these problems as it can outside of the framework of government?

I'm not being "Pollyanna-ish" when I say that I have faith and confidence that we will do many of these things, although I recognize that it is going to take a lot more effort and understanding in the future than it has in the past.

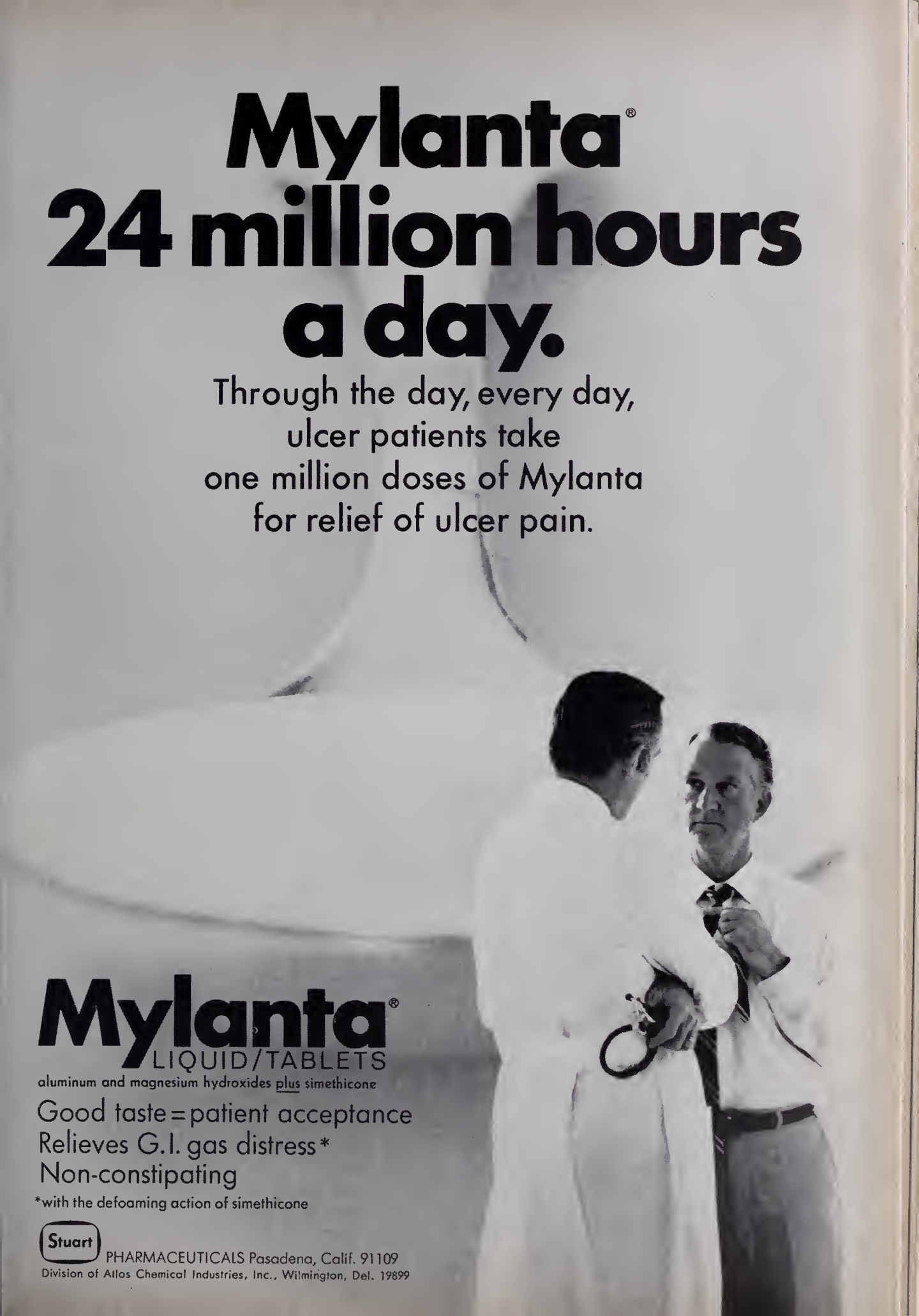
Free choice—voluntarism and individualism—cannot and must not be discussed and dismissed as meaningless slogans. The great strength of America comes from freedom, from the vitality, ingenuity, leadership, community service of individual citizens and voluntary organizations, such as yours, not just the size and power of government.

If we, ladies and gentlemen, expect to maintain our present freedom, or have anything to say about our future destinies, we must put forth, voluntarily, the effort required. Let us not underestimate in any way those threats we face.

I want, in closing, to express, on behalf of our Boards and staff, and personally, our sincere appreciation to the Kentucky Medical Association for its leadership and for all it has done to make voluntary prepayment work in Kentucky. Together, there is much more we can do.

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The Pregnant Person

William K. Keller, M.D.

THIS particular title is used to place the emphasis on the person who is pregnant and not the pregnancy itself. Let us assume that the person we are talking about is a happily married, relatively young primipara who is expressing enough of the usual early signs and symptoms of a normal pregnancy to bring her to you. She wants confirmation of this pregnancy and the assurance that you will care for her on through delivery and the post partum period. Let us assume further that your routine history and examination show no evidence of anything but a normal or usual healthy pregnancy.

Now what of this person herself? Is she worried, anxious, afraid or is she completely without any qualms or apprehension? It would be hoped that if she were as normal as her pregnancy she would have some normal anxieties and worries and this is where we doctors come in. It is all very well to say to her "You have nothing to worry about" or "You will have a fine baby" or "You are in excellent health and should have no problems at all" but what we do not know and what we must determine is what questions and anxieties does *she* have about this pregnancy? What are her worries? What murky folklore shadows does she need factual light on?

Some of us rely too heavily on our "inherently endowed omnipotence" to give blanket reassurance to worried individuals. However, we must face up to our lack of absolute knowledge concerning our patients and make a real attempt to understand them. This procedure involves no hocus pocus, is not a trade secret of a psychiatrist, and does not involve obscure or occult formulae. It is simply a commonsense procedure which every physician is duty-bound to employ and improve his skills in its use. The "trick" is so simple that most of us believe we employ it, yet too many do not. That "trick" is to listen—not necessarily to the words the patient is using but for the meaning she is trying to convey. Listen not to hear some pseudo-intellectualized profundity, but to learn what really concerns her. People, even as you and I, have some very peculiar ideas, so why can't our patients have some, too?

There is much in the folklore about pregnancy, and unless we know what she is thinking we can't allay her fears. So by allowing her to talk and listening to her with undivided, respectful interest, you will encourage her to tell you more and more and ask your help in understanding many of her anxieties. Suppose she had one of those mothers who had always told of her profound suffering in delivery, or close brush with, or near escape from, death in childbirth. Wouldn't she naturally and normally be worried about the delivery herself? Isn't she entitled to a few minutes of your time given to a simple, non-technical (Oh Lord, help us poor physicians to talk to our patients non-technically!) explanation of delivery and of modern advances and techniques? Perhaps someone had told her of Mrs. So-and-So who did this or that when she was pregnant, and as a consequence had a deformed child. Is she not entitled to an uncomplicated statement of what really few things one can do, or leave undone for that matter, which will affect a child adversely? In fact, shouldn't she be told just how few such children there are? She would have heard of Thalidomide and she merits knowing its current status. Any drugs given her should be carefully discussed as to expected results, as well as concomitant reassurances concerning side effects.

If we prescribe an optimum diet and exercise, should we not also advise her about sexual activities? One would guess that there is more misinformation about sex than any other form of universal human activity. One hears of one OB man prohibiting sexual intercourse in the early stages of pregnancy, then again for from two to three months before delivery. This same man would probably prohibit sexual intercourse from one to two months after delivery.

Now, excluding such obvious conditions as bleeding, cramping, or the rupture of membranes before delivery, and just plain physical discomfort for a short time afterward, why in heaven's name should such prohibitions be demanded? The average woman has so many feelings of loss of attractiveness during her pregnancy that at this time above all she needs to be loved. She needs to be assured of this love and to know that an expression of this love is normal. Whenever such abstemious advice is offered, one is reminded of a teacher of OB who advised her students that it was normal for women to have an orgasm in only about one out of ten sexual experiences. This teacher was a maiden lady and could only advise from information given her by her patients, who, in general, seemed to have lived a somewhat arid sex life and to have been given rather short shrift at home. It is to be hoped that their husbands were more successful on the Rialto.

And speaking of husbands, they should be included quite early in this talking out business, for many of them know even less than their wives about this whole process. It is amazing how ignorant of childbearing some of them can be. Many of them feel guilty enough as it is and need to have their fears and anxieties cared for in a similar manner. This family discussion calls for commonsense evaluations of these two people. You, as the physician, must decide, and in each case individually, whether or not these two people should be seen together or by themselves. Guidance in this matter can often come from the wife, for our wives tend to know us quite well. One or both might be concerned over "natural" childbirth, hypnosis, or anesthetic. A few minutes taken to explain your own routine procedures will eventuate in a much more comfortable person who is progressing with a normal pregnancy—a comfortable

(Continued on page 470)



you can hang on for a few more minutes, Doctor, n sure I'll sneeze again."

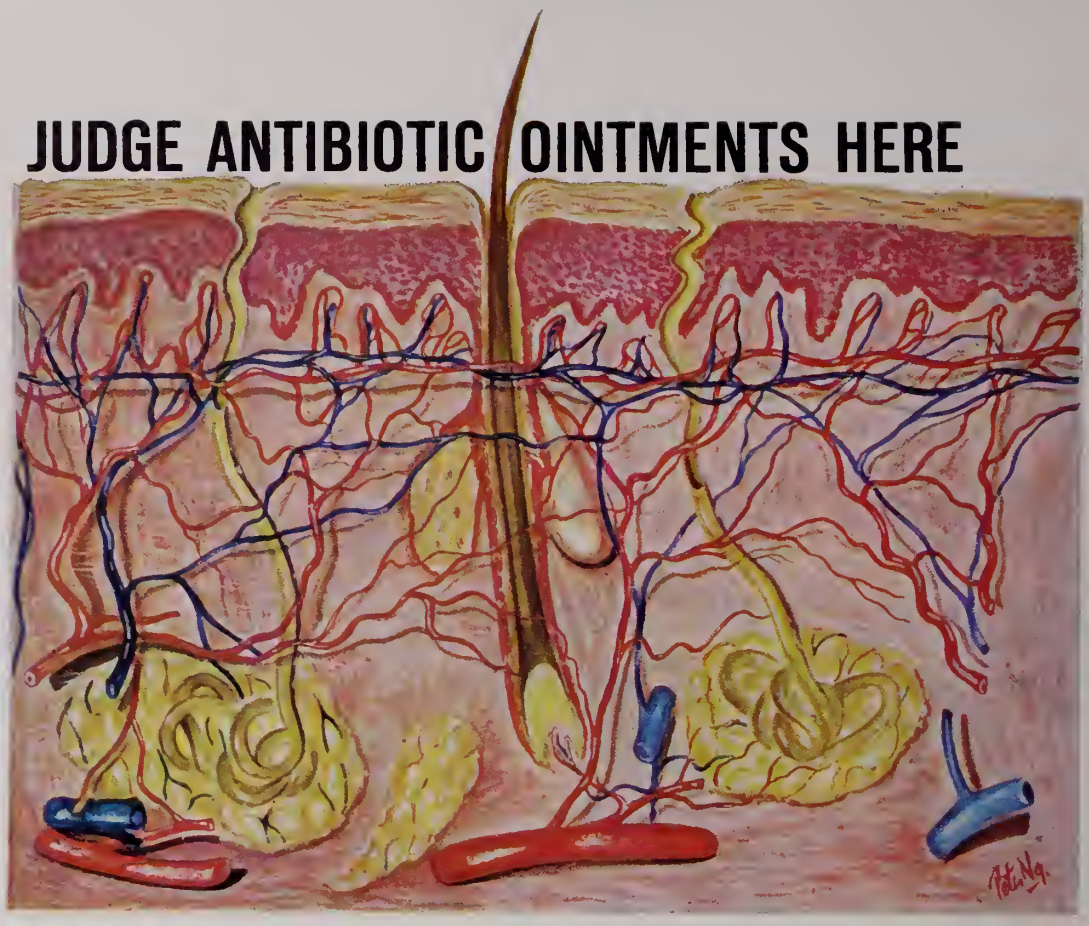
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PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between doses rather than lessening the recommended dose is preferable. The prompt direct action allows a conscious sense of the first suggestion of return of symptoms as a guide to dosage spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

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Endurets®
prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

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Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

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For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

•Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

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EDITORIALS

Hospital Beds—We Need 'Em

IN RECENT months there has been expressed considerable difference of opinions regarding the adequacy of hospital accommodations for patients. While beds seem to be at a premium always and are often not available at all for even the critically ill, it has been claimed by some that this condition is simply due to over-utilization—that actually we have adequate beds now if rightly used. To arrive at a reasonably accurate conclusion so far as our community is concerned, the Jefferson County Medical Society did a one-day survey of almost 2000 occupied beds in our several hospitals. It was found that 7.3 per cent of the patients reviewed were actually not in need of hospital care. Another 15.5 per cent could well be receiving hospital-based minimal care. It was concluded from this survey that there is not really a problem of gross over-utilization of hospital beds in this city.

It is difficult for one physician to decide accurately that another doctor's patient does not need to be hospitalized, but we accept the 7.3 per cent of patients so classified. We constantly try to prevent this—to reduce this percentage to the lowest figure possible. Rarely is a patient put in the hospital unnecessarily on the judgement of the attending or the referring physician. Usually it is upon the patient's or his family insistance—either because he is scared or because there will be a monetary advantage in having a minor illness or diagnostic procedure carried out there rather than at home. The physician is usually inclined to give the patient the benefit of any reasonable doubt and may thus yield to his insistence that he is more acutely ill than he appears to be. Whatever the causes may be most physicians try constantly to reduce this abuse, comparatively small though it be.

The 15.5 per cent who could do as well with hospital minimal care constitutes the basis for concern for most of our utilization committees. If every patient could be discharged just one day earlier than they are it would greatly lighten our pressure for beds, yet this is not easy. Most of us have discharged patients on the earliest date that seemed feasible—sometimes against the patient's preference —to find later that we were mistaken—that a little longer care might have prevented recurrence of the illness and an additional hospitalization.

In this minimal care group 214 patients were listed for convalescent care and 92 for diagnostic services. It is among the convalescent patients that we have constant difficulty and this number or percentage probably can be reduced with diligent care and at no especial hazard to the patients' welfare. Private insurance companies and Blue Cross have always tried to exclude diagnostic admissions from their responsibility, and with reason, because their contracts often specifically state that they are not covered. Yet by no means do all diagnostic admissions deserve to be denied hospital service or insurance coverage. Such admissions are necessary in many cases for three specific reasons—1) for diagnostic tests not readily available in accessible laboratories, 2) for daily observation and 3) for consultation. It seems unfair therefore to list diagnostic admissions generally as abuse of hospital services.

We deal here with reasonably low percentages of error or over-utilization—and by any reasonable criteria it must be acknowledged that our present supply of hospital beds is insufficient to meet the increasing demand. The Health Facilities Council has for a long time questioned this conclusion but during the past two months has expressed approval of the plans to build the Norton-Children's complex and to expand both the Jewish and Methodist-Evangelical Hospitals. This was done with the provision however that a substantial number of minimal care accommodations be included in any program of expansion. This is an acceptable restriction generally but should not be very rigid. There will be times of epidemic or seasonal sickness when minimal care beds will be urgently needed for acutely or critically ill patients. Other plans for building or enlarging hospitals in this area are in the making but less advanced. It is not likely that in any case the supply of beds will catch up with, not to mention overtake, the demand in the near future.

* * * * *

Under lively discussion now in Louisville is whether a new teaching hospital in connection with our medical school should be built at the phenomenally high cost of somewhere between 30 and 43 million dollars. There are several reasons to believe that this is not such a fantastic or unreasonable plan. The era of the big "free" or "charity" teaching hospitals which provided clinical material for most of our medical schools is past. These hospitals are now in process of being phased out. The teaching hospital of the future will almost certainly be for private, pay or insurance covered patients under the personal care of the teaching staff of the medical school. The

part-time, voluntary physician in private practice already has a far less important part than previously in teaching medical students and this practice seems scheduled for greater and greater reduction to the vanishing point in most of our medical schools. If the full-time faculty is to do the teaching there must be hospital facilities available—and they can no longer find this in free or charity hospitals.

During the past ten years the trustees and staff of the Methodist Evangelical Hospital have tried honestly and persistently to make it available to the University of Louisville School of Medicine as a teaching institution. Through the administration of two Deans our efforts have availed nothing—partly because the school required more complete control of the hospital staff than they were willing to yield, and also because the part-time, voluntary faculty member seemed not so urgently needed as in previous years. The same has been true to a greater or lesser extent with the Jewish Hospital nearby in the Medical Center. There is hope that the proposed Norton-Children's Hospital will become a more integral part of the Medical School but this remains to be seen.

At the time when these changes in teaching are in process our present General Hospital is old and antiquated despite its many renovations and additions. The original hospital was built more than 50 years ago. While a sturdy and substantial structure, it can hardly be adapted to the needs of our enlarged and modern medical school facilities for many, or even a few, more years. We are not alone in such a dilemma as noted by the same problems regarding many of our ancient and time-honored general charity hospitals—Cincinnati General and Cook County in Chicago—to mention only two.

The School of Medicine of the University of Louisville has enjoyed a very long and distinguished period of service to the Medical profession and to humanity. This year it is moving, with the Dental School, into new, modern and greatly enlarged quarters. The freshman class this year will be 128 instead of 96. An expanding period of usefulness is beginning. But with inadequate teaching and hospital facilities we cannot continue the quality of service nor maintain our enviable place in Medical Education which has been the tradition for more than a hundred years. It is difficult to attract and hold the highest calibre of faculty men under the present conditions. Whether it is done now or in the near future—whether at one time or step by step, is not so very important but an adequate teaching hospital for the faculty should have highest priority.

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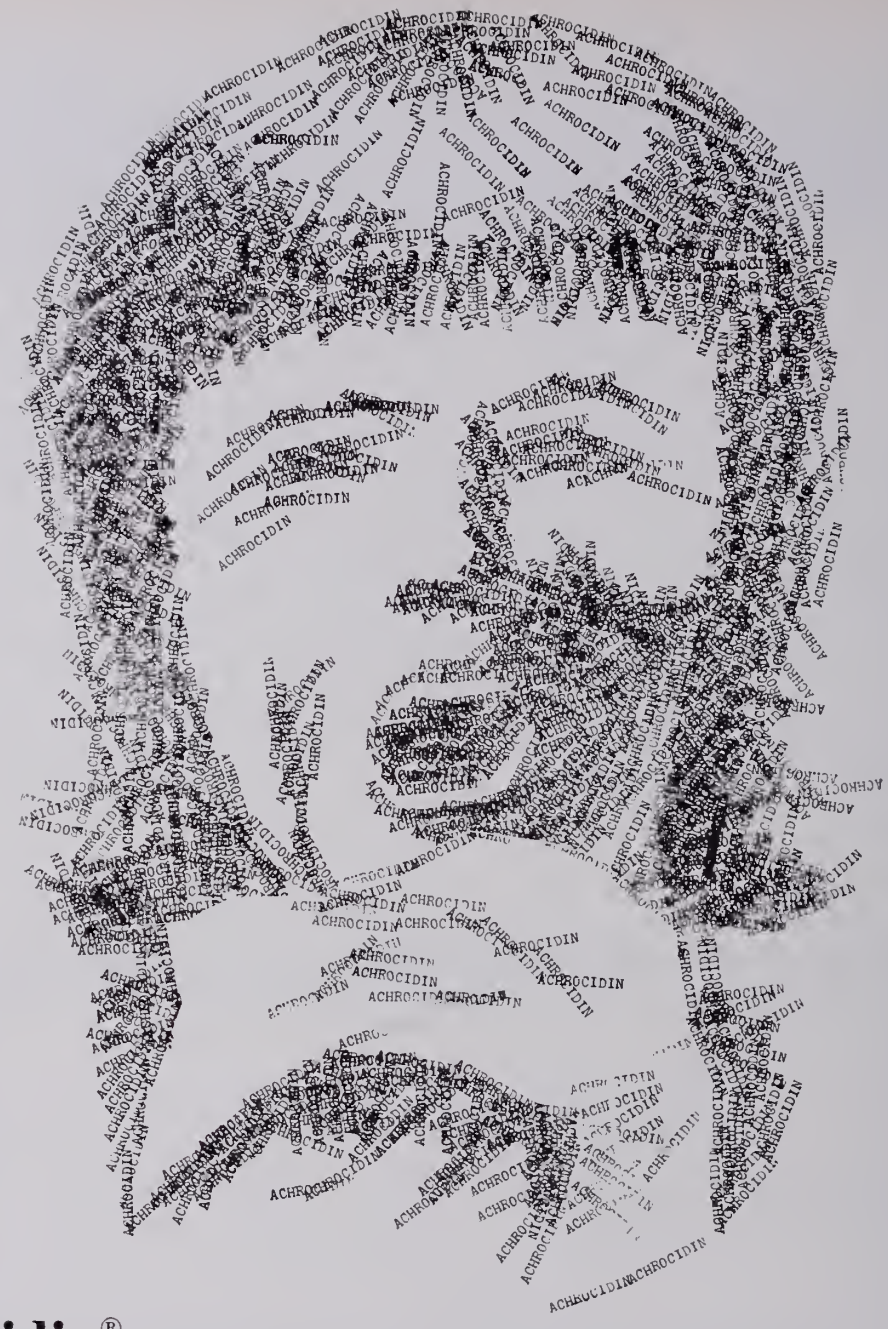
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ORGANIZATION SECTION

Out-of-State Guest Speakers to Participate on Scientific Program With Kentucky Physicians at KMA Annual Meeting, Sept. 22-24

Participating with Kentucky physicians in panel discussions and scientific presentations during the 1970 KMA Annual Meeting September 22-24 will be well-known medical authorities from across the nation. The discussion will highlight the four general scientific sessions at Louisville's Convention Center.

Bradley E. Smith, M.D., Nashville, Tenn., will be the speaker at the opening session of the scientific program on Tuesday, September 22. David E. Shoch, M.D., Chicago, Ill., and Marvin A. Block, M.D., Buffalo, N.Y., will take part in the Thursday morning general session dealing with "Industrial Medicine." Jerome W. Conn, M.D., Ann Arbor, Mich., will be featured on the scientific program as a guest of the Kentucky Academy of General Practice.



Doctor Smith

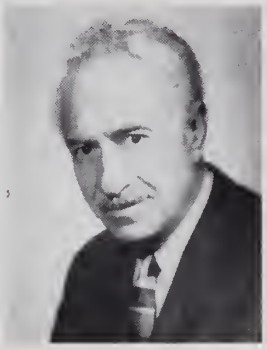


Doctor Shoch

The scientific program will also feature presentations and discussions on such themes as "Emergencies," "Cardio-Pulmonary Resuscitation," and "Tuberculosis." A Crackerbarrel Session is scheduled for the Wednesday afternoon session, September 23.

In addition to the scientific program, the session will include the meetings of 16 specialty groups, two sessions of the KMA House of Delegates, the annual convention of the Woman's Auxiliary, an Orientation Program for new members, more than 75 scientific and technical exhibits, University of Louisville Alumni Reunions, the annual KEMPAC Seminar and a number of miscellaneous meetings to be announced in the Annual Meeting Program Booklet.

A guest of the Kentucky Society of Anesthesiologists, Doctor Smith is professor and chairman of the department of anesthesiology at Vanderbilt University School of Medicine. A 1957 graduate of the University of Oklahoma, Doctor Smith is a Fellow of the American College of Anesthesiologists and Associate Fellow, American College of Obstetricians and Gynecologists.



Doctor Block



Doctor Conn

Doctor Shoch, a guest of the Kentucky EEN&T Society, will speak on "Diabetic Ophthalmopathy." Professor and chairman of the department of ophthalmology at Northwestern University Medical School, he received his Ph.D. in 1943 and his M.D. in 1945 from Northwestern University. He is a member of the American Board of Ophthalmology and a trustee of the Association of University Professors in Ophthalmology.

Speaking at the Thursday morning session on "Alcoholism," Doctor Block is assistant professor of clinical medicine at the University of New York School of Medicine. A guest of the Kentucky Industrial Medical Association, Doctor Block is vice president of the American Medical Society on Alcoholism and chairman of the Subcommittee on Alcohol and Drugs of the President's Committee on Traffic Problems.

Doctor Conn is the Louis Harry Newburgh Distinguished University Professor of Internal Medicine and director of the department of endocrinology and metabolism and the Metabolism Research Unit of the University of Michigan Medical School. Serving as an expert consultant in chronic degenerative disease of the World Health Organization, Geneva, Switzerland, Doctor Conn is a past president of the American Diabetes Association and the Central Society for Clinical Research. He will be speaking on "Aldosteronism in Hypertensive Disease."

WATCH FOR

THE AUGUST JOURNAL

Complete Annual Meeting Details

1970 Scientific Program Outline Released for Annual Mtg.

The following preliminary scientific program for the 1970 KMA Annual Meeting was released by KMA President Walter L. Cawood, M.D., Ashland. Each half-day session of the three-day program will feature a 30-minute intermission in order that physicians may visit the scientific and technical exhibits. The program will be presented at Convention Center, Louisville.

TUESDAY, SEPTEMBER 22

Morning Session

THEME: "Emergencies"

Opening Ceremonies

"Emergency Treatment of Aspiration Pneumonia"—Bradley E. Smith, M.D., Nashville, Tenn.

"Evaluation and Management of Drug Reactions"—William Lester, M.D., Denver, Colo.

"Croup"—Margaret H. D. Smith, M.D., New Orleans, La.

"Psychiatric Emergencies"—Shervert Frazier, M.D., New York, N.Y.

"Urologic Emergencies"—Donald J. Jaffar, M.D., Southfield, Mich.

"Vascular Injuries Associated with Fracture"—J. Leonard Goldner, M.D., Durham, N. C.

Afternoon Session

Eight of the 16 participating specialty groups will meet at 2 p.m. There will be no general scientific session at that time.

WEDNESDAY, SEPTEMBER 23

Morning Session

THEME: "Cardio-Pulmonary Resuscitation"

"The Nurse in Emergency Cardio-Pulmonary Resuscitation"—FILM

"Ventilation and Circulatory Support"—Donald M. Thomas, M.D., Louisville

"Useful Drugs and Cardio-Pulmonary Resuscitation"—Borys Surawicz, M.D., Lexington

"Electrical Equipment"—Leonard Leight, M.D., Louisville

"The Current Status and Future Direction of Intensive Coronary Care"—Lawrence E. Meltzer, M.D., Philadelphia, Pa.

"Artificial Organs and Human Transplantation"—C. Walton Lillehei, M.D., New York, N.Y.

Scientific Exhibit Award Presentation

Afternoon Session

"The Future for the Coronary Disease Patient—Medicine or Surgery?"—C. Walton Lillehei, M.D., New York, N. Y.

"Principles of Treating Cardiogenic Shock"—Lawrence E. Meltzer, M.D., Philadelphia, Pa.

"Common Lesions of Oral Tissues"—Robert R. Finch, D.D.S., Louisville

"Crackerbarrel Session"

THURSDAY, SEPTEMBER 24

Morning Session

THEMES: "Industrial Medicine" "Tuberculosis"

"Diabetic Ophthalmology"—David E. Shoch, M.D., Chicago, Ill.

"Cutaneous Reactions to Some Environmental Intoxicants"—Donald J. Birmingham, M.D., Detroit, Mich.

"Alcoholism"—Marvin A. Block, M.D., Buffalo, N.Y.

"Chemotherapy of Tuberculosis"—Vernon N. Houk, M.D., Atlanta, Ga.

"Problems in TB Therapy"—panel discussion
George F. Brockman, M.D., Greenville, moderator
Thomas S. Moulding, M.D., Denver, Colo.
Vernon N. Houk, M.D., Atlanta, Ga.
Richard B. McElvein, M.D., Lexington

Afternoon Session

The remaining eight specialty groups will meet at 2 p.m., with the exception of the Kentucky EEN&T Society which will begin their meeting at 9 a.m. No general session is scheduled for the afternoon.

Ky. Ob-Gyn Society Names Dr. Greene President

John W. Greene, Jr., M. D., Lexington, was elected president of the Kentucky Obstetrical and Gynecological Society at its 22nd Annual Spring Meeting held May 15 and 16 in Louisville.

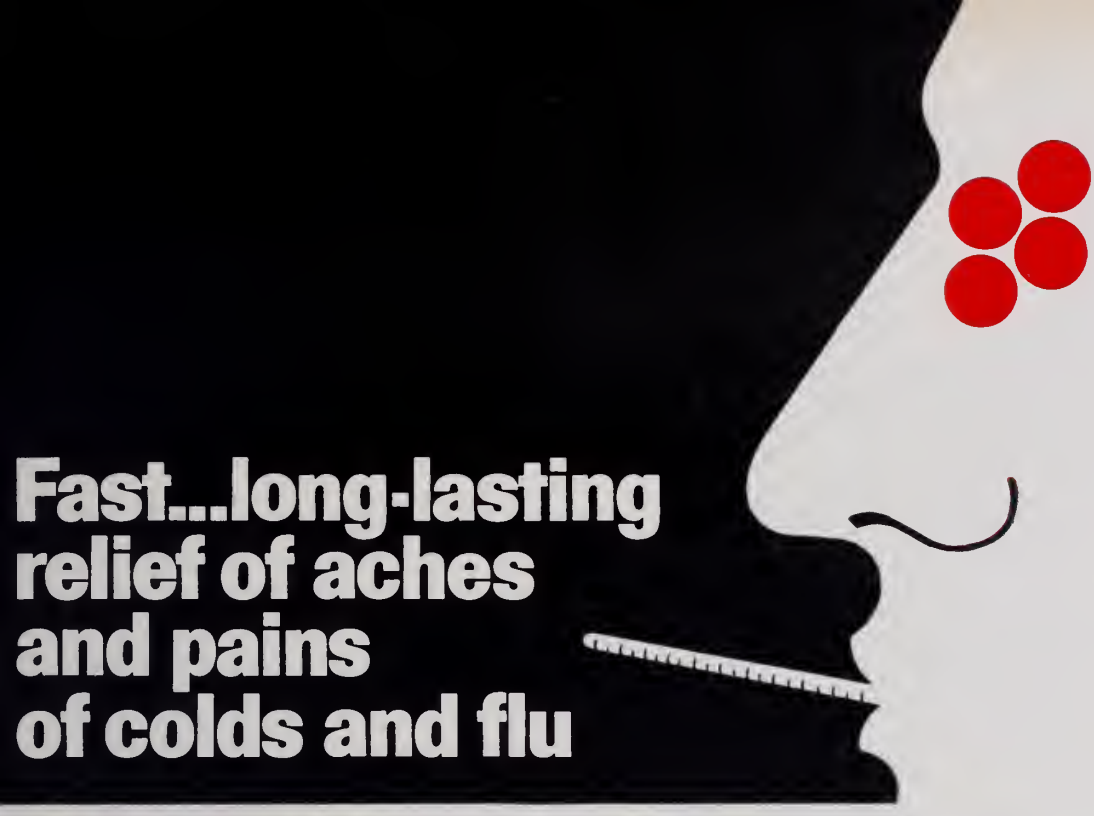


Doctor Greene

Chairman of the department of obstetrics and gynecology at the University of Kentucky College of Medicine since 1962, Doctor Greene is a 1952 graduate of the University of Pennsylvania School of Medicine. Before coming to Kentucky, he was assistant professor of obstetrics and gynecology at the University of Pennsylvania.

Other officers elected during the meeting were C. J. McGruder, M.D., Henderson, vice president and Mervel V. Hanes, M.D., Louisville, secretary-treasurer.

The meeting, which was partially supported by the Kentucky Division of the American Cancer Society, featured a Symposium on Pelvic Cancer. Guest speakers on the symposium were Professor Stanley Way, New Castle-on-Tyne, England; James S. Krieger, M.D., Cleveland, Ohio; John Lewis, M.D., New York, N. Y., and J. Donald Woodruff, M.D., Baltimore, Md.



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Annual Mtg. of 4th District To Be July 16 in Lebanon

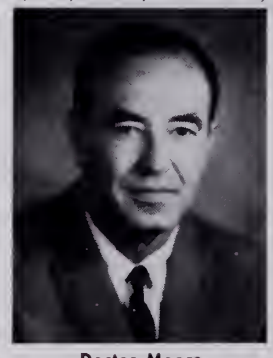
The Fourth Trustee District of KMA will hold its annual dinner meeting at 6 p.m. July 16 at Trosino's Restaurant in Lebanon, according to W. Bruce Hamilton, M.D., Shepherdsville, trustee for the district.

Immediate Past President Henry B. Asman, M.D., Louisville, will discuss the proposed KMA dues increase to be acted upon by the House of Delegates this September. In addition, Marvin A. Bowers, Jr., M.D., Louisville, chairman of KMA's Claims and Utilization Review Committee, will speak on the role of county and district peer review committees.

All physicians and their wives in the Fourth District are invited to attend the meeting, Doctor Hamilton said.

Ky. Chapter of Surgeons Choose Dr. Moore As Pres.-Elect

The Kentucky Chapter, American College of Surgeons chose Roy H. Moore, Jr., M.D., Louisville, as its president-elect at their annual meeting, March 12-14 at the Imperial House, Lexington.



Doctor Moore

Doctor Moore, who was president of the Jefferson County Medical Society from 1965-66 and served as KMA vice president in 1966, is currently medical staff president at Methodist Evangelical Hospital. A 1939 graduate of the University of Louisville School of Medicine, Doctor Moore belongs to the Falls Regional Health Council and is a member of the Innominate Society, a local historical group.

Delmas Clardy, M.D., Hopkinsville, was installed as president of the Chapter. Other officers of the Chapter are Sam D. Weakley, M.D., Louisville, secretary-treasurer and newly elected Council member Walter R. Johnson, M.D., Paducah.

Dr. Wm. McElwain Appointed As State Health Chief

William P. McElwain, M.D., Lexington, will become Kentucky's state health commissioner September 1. The state Board of Health appointed McElwain to succeed Russell E. Teague, M.D., upon the latter's retirement in August, according to George P. Archer, M.D., Prestonsburg, president of the state Board.

A career public health officer, Doctor McElwain, 37, will serve as acting commissioner while Doctor Teague, who has been commissioner since 1956, recuperates from a heart attack suffered April 24.

Doctor McElwain, who has been director of local health services in the Health Department since September, came to the state office from the Lexington-Fayette County Health Department where he was associate director for 15 months.

A native of Bowling Green, Doctor McElwain graduated from the University of Louisville School of Medicine in 1958 and later received his master's degree in public health from Johns Hopkins University. His work in public health began in 1961 when he joined the U. S. Public Health Service, working in New Mexico, Arizona, Oklahoma and Washington, D. C., where he was a consultant to the Peace Corps and the State Department.

Doctor McElwain is Kentucky's sixth health commissioner.

Dr. Funk Named Pres.-Elect Of Ky. Surgical Society

Jesse T. Funk, M.D., Bowling Green, was chosen as president-elect of the Kentucky Surgical Society at its 1970 Annual Meeting held May 15-16 at Kentucky Dam Village State Park.



Doctor Funk

A fellow of the American College of Surgeons, Doctor Funk was a KMA vice president from 1954-55. A graduate of Vanderbilt University, he did his hospital training at Good Samaritan Hospital, Lexington and St. Thomas Hospital, Nashville, Tenn.

Edward H. Ray, M.D., Lexington, was installed as the Society's president for the coming year. Doctor Ray succeeds Blaine Lewis, M.D., Louisville, in this capacity.

The next annual meeting of the Society is scheduled for May 14-15, 1971 at Cumberland Falls State Park.

Ky.'s Congressmen Honored At KMA Washington Dinner

The Thirteenth Annual KMA Washington Dinner honoring the state's U. S. senators and representatives was held June 2 at the Mayflower Hotel, Washington, D. C.

A total of 65 persons, including the congressmen and their wives, administrative assistants and their spouses, and KMA members, attended the event. KMA officers, members of the Committee on Legislative Activities, congressional keymen, KEMPAC directors, Woman's Auxiliary members and staff represented the Association.

A briefing session was held at the AMA Washington Headquarters Office on the night prior to the dinner for KMA physicians and wives, AMA representatives, and KMA staff. In addition to the dinner, KMA physicians made visits to the senators and representatives' offices.

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Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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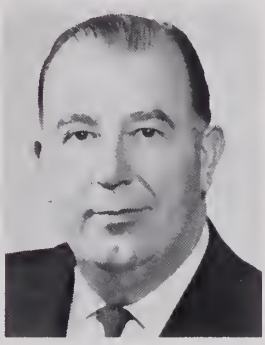
Specific therapy for night leg cramps

Two U. S. Senators To Speak At Annual KEMPAC Seminar

Two U. S. Senators, Edward J. Gurney (R), Florida and Jennings Randolph (D), West Virginia will be the guest speakers at the annual KEMPAC Seminar which precedes the KMA Annual Meeting.



Senator Gurney



Senator Randolph

C. Kenneth Peters, M.D., Louisville, chairman of the KEMPAC Board of Directors, has announced that a reception, followed by a dinner and the Seminar, will begin at 6 p.m., Monday, September 21. in the Flag Room of the Kentucky Hotel.

Senator Randolph and Senator Gurney have been asked to discuss "Physician Involvement in Government" and "Government Involvement in Medicine," according to Doctors Peters.

Prior to Senator Gurney's election to the Senate in 1968, he served in the U. S. House of Representatives in the 88th, 89th and 90th Congresses. He now serves on the Committee on Government Operations, Public Works Committee, Special Committee on the Aging and the Republican Campaign Committee.

Senator Randolph, elected to the U. S. House of Representatives in 1932, served 14 consecutive years in that capacity. In 1958 he was elected to the U. S. Senate to complete the term ending January, 1961. He was then re-elected in 1960 and 1966. Senator Randolph serves on the Committee on Public Works as its chairman, Committee on Labor and Public Welfare, Committee on Post Office and Civil Service, Select Committee on Small Businesses, Special Committee on Aging and Select Committee on Equal Educational Opportunity.

The KEMPAC Board of Directors urges all physicians and their wives to make plans now to attend this exciting and informative affair.

U.K. Medical Library Provides Free Phone Reference Service

The Albert B. Chandler Medical Center Library at the University of Kentucky Medical Center, Lexington, is now providing physicians and other health professionals in Kentucky direct access to medical literature by the use of a new toll-free long distance telephone service.

Mrs. Betty Maxson, extension librarian for the Ohio Valley Regional Medical Program, sponsor of the telephone library service, says the service is offered to physicians, dentists, nurses, pharmacists, technicians, dietitians, hospital administrators, therapists, public health personnel, lawyers working on medical cases and anyone else who works with the health sciences and needs medical or related information.

Library officials report that the library received more than half the number of requests during the program's first 16 days than it had during the preceding nine months. The program began operation on April 2.

Services of the OVRMP long distance telephone operation include help with ordering books, gathering statistical information, getting background information on certain diseases, photocopying and mailing of journal articles, and preparing bibliographies on particular subjects.

Calls on the In-WATS line are handled by librarians each weekday from 8 a.m. to 5 p.m. A tape answering device records calls during evening hours and weekends. The In-WATS number for the medical library extension service is 800-432-9516.

New Diagnostic Computer in Ky.

A computer system designed to assist physicians in the diagnosis of acquired and congenital pediatric diseases has been installed at the Hopkins County Hospital in Madisonville.

The system, called Computer Assisted Diagnosis (CAD), is marketed by Mead Johnson Laboratories, Evansville, Ind. A physician can call the computer via a teletypewriter installed in his office or hospital and enter his findings on a patient. The computer then lists those diseases or syndromes related to the patient's symptoms. Scientific contributors insure that the information in the computer's memory bank is as current as possible.

Insurance Page

(Continued from page 419)

The preceding remarks are not necessarily the opinion of the insurance editor. They were presented for the information of the Medical Association. It is hoped that these remarks may have some educational value.

LEWIS DICKINSON, M.D.

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Pathologists Elect Dr. Neudorfer

The Kentucky Society of Pathologists, at their annual spring meeting, chose Karl M. Neudorfer, M.D., Ashland as its president-elect. Doctor Neudorfer practices at Kings Daughters Hospital in Ashland.

The program, which was presented by Duane N. Tweeddale, M.D., Richard P. O'Neill, M.D., and Arthur Lieber, M.D., all of Lexington, was on "Radiologic, Clinical and Psychologic Changes in Pulmonary Neoplasms."

Medical Assistants Annual Mtg. Held May 15-17 in Louisville

The Kentucky Society, American Association of Medical Assistants installed Mrs. Guthrie Veech, Louisville as their 1970-71 President at their Eighth Annual Convention, held May 15-17 in Louisville.

Mrs. James Pleasant, C.M.A., Madisonville, was chosen as the Society's president-elect. Other officers installed were Miss Erlene Russell, Lexington, vice-president; Miss Pat Kelly, Louisville, recording secretary; Mrs. Carolyn Kelly, Louisville, treasurer, and Mrs. Faye Jordan, Louisville, corresponding secretary.

Guest physicians appearing on the program included J. Murray Kinsman, M.D., Jerry Seligman, M.D., and Allan M. Lansing, M.D., all from Louisville. Mrs. Marie Young, president-elect of the American Association of Medical Assistants spoke to the group on "Membership."

Mrs. Veech, a past president and vice-president of the Jefferson County Medical Assistants, is also a former vice-president of KAMA.

The Pregnant Person

(Continued from page 454)

person who will, should unforeseen complications develop, have such confidence in you and your intellectual honesty that she will automatically endow you with inherent omnipotence and leave the worrying to you. That's your job.

And, finally, when that person who was pregnant has been competently delivered and is now a proud and happy mother of a lovely child, you can enjoy that big pay off for the true physician—the inner satisfaction that comes from a good job well done, and the rewarding knowledge that through your art as well as your scientific know-how you have brought health, comfort, and happiness to another human being.

Survey Finds Placement Services Influence Physician Locations

The American Medical Association recently published the findings of a survey on 2,468 physicians practicing in nonmetropolitan areas of the United States. The findings, published in Volume 85 of *Public Health Reports,* were compiled by Bond L. Bible, Ph.D., secretary of the AMA Council on Rural Health.

One response of the survey indicated that influences on choice of practice sites were "best opening," geographic preferences, family and friends, leads from colleagues or others, nearby place of internship, and assistance from AMA and medical society placement services.

The KMA Physician Placement Service is eager to be of assistance to physicians seeking associates and to those physicians desiring to locate in the state.

The KMA Service compiles a quarterly report entitled "Physicians Seeking Locations" which is available to any physician upon request. Names on this list include scholarship recipients, recent medical school graduates, physicians discharged from military service and doctors who have inquired at KMA or the AMA about available locations in Kentucky. "Opportunities for Practice", a semi-annual report, is also available upon request to those wishing to practice in the state. Physicians are encouraged to make use of this service.

PHYSICIANS DESIRING ASSOCIATES OR REPLACEMENTS IN SPECIALTY AREAS

County	City	County	City
		ANESTHESIOLOGY	
Barren	Glasgow	Muhlenberg	Greenville
Daviess	Owensboro	Pike	Pikeville
Hopkins	Madisonville	Rowan	Morehead
		CARDIOLOGY	
Calloway	Murray	Harlan	Harlan
		ENT (OTOLARYNGOLOGY)	
Barren	Glasgow	Harlan	Harlan
Daviess	Owensboro	Hopkins	Madisonville
Christian	Hopkinsville	Pike	Pikeville
Hardin	Elizabethtown	Warren	Bowling Green

DERMATOLOGY

Daviess	Owensboro	Pike	Pikesville
	Warren	Bowling Green	

INTERNAL MEDICINE

Barren	Glasgow	Lawrence	Louisa
Christian	Hopkinsville	Madison	Richmond
Daviess	Owensboro	Mason	Maysville
Graves	Mayfield	Muhlenberg	Greenville
Hardin	Elizabethtown	Pike	Pikeville
Harlan	Harlan	Pulaski	Somerset
Henderson	Henderson	Shelby	Shelbyville
Hopkins	Madisonville	Warren	Bowling Green

NEUROLOGY

Hopkins	Madisonville		

NEUROSURGERY

Hopkins	Madisonville	Pike	Pikeville

OB-GYN

Barren	Glasgow	Harlan	Harlan
Floyd	McDowell	Letcher	Whitesburg
Greenup	Russell	Madison	Berea
Daviess	Owensboro	Mason	Maysville
Hardin	Elizabethtown	Pike	Pikeville
	Rowan	Morehead	

OPHTHALMOLOGY

Daviess	Owensboro	Madison	Berea
Hardin	Elizabethtown	Pike	Pikeville
	Warren	Bowling Green	

ORTHOPAEDIC SURGERY

Christian	Hopkinsville	Pike	Pikeville
Graves	Mayfield	Scott	Georgetown
Hopkins	Madisonville	Warren	Bowling Green

PEDIATRICS

Bell	Middlesboro	Letcher	Whitesburg
Daviess	Owensboro	Mason	Maysville
Floyd	McDowell	Muhlenberg	Greenville
Harlan	Harlan	Perry	Hazard
Henderson	Henderson	Pike	Pikeville

PATHOLOGY

Hopkins	Madisonville	Pike	Pikeville

PSYCHIATRY

Jefferson	Louisville	Pike	Pikeville

RADIOLOGY

Barren	Glasgow	Pike	Pikeville
	Warren	Bowling Green	

SURGERY

Garrard	Lancaster	Mason	Maysville
Greenup	Russell	Pendleton	Falmouth
Madison	Berea	Pike	Pikeville
	Scott	Georgetown	

UROLOGY

Calloway	Murray	Mason	Maysville
Graves	Mayfield	Pike	Pikeville

KMA Plans and Development Committee

Thornton E. Bryan, Jr., M.D., Cadiz, Chairman

KMA Headquarters Office **June 10, 1970**

The KMA Plans and Development Committee held their third meeting during this Associational year with special guests representing public relations firms in attendance. The committee's two primary subjects under discussion included the feasibility of KMA utilizing outside public relations consultants and a continuing effort to coordinate the services of specialty groups and other medical organizations.

The committee heard representatives of two PR firms discuss proposals relating to what their organizations could do for KMA. A definitive recommendation was made to the Board of Trustees. In addition, representatives of various specialty groups were in attendance to further discuss utilizing KMA to house administrative services for specialty group organizations. The committee agreed that an Interspecialty Council should be established to pursue this subject.

Advisory Committee to Blue Shield

Kenneth P. Crawford, M.D., Louisville, Chairman

KMA Headquarters Office **June 4, 1970**

The Advisory Committee to Blue Shield recently held their annual meeting and were pleased to have representatives of the Blue Shield staff in attendance.

There were many items discussed by the committee and specific attention was directed to the Usual, Customary and Reasonable Program approved by the House of Delegates and implemented by Kentucky Physician's Mutual.

The committee plans to make a full report on this program and other items relating to the pre-payment system to the House of Delegates in September. In addition, the percentage of physicians, by county, participating in the UCR Program will be noted for the House of Delegates consideration.

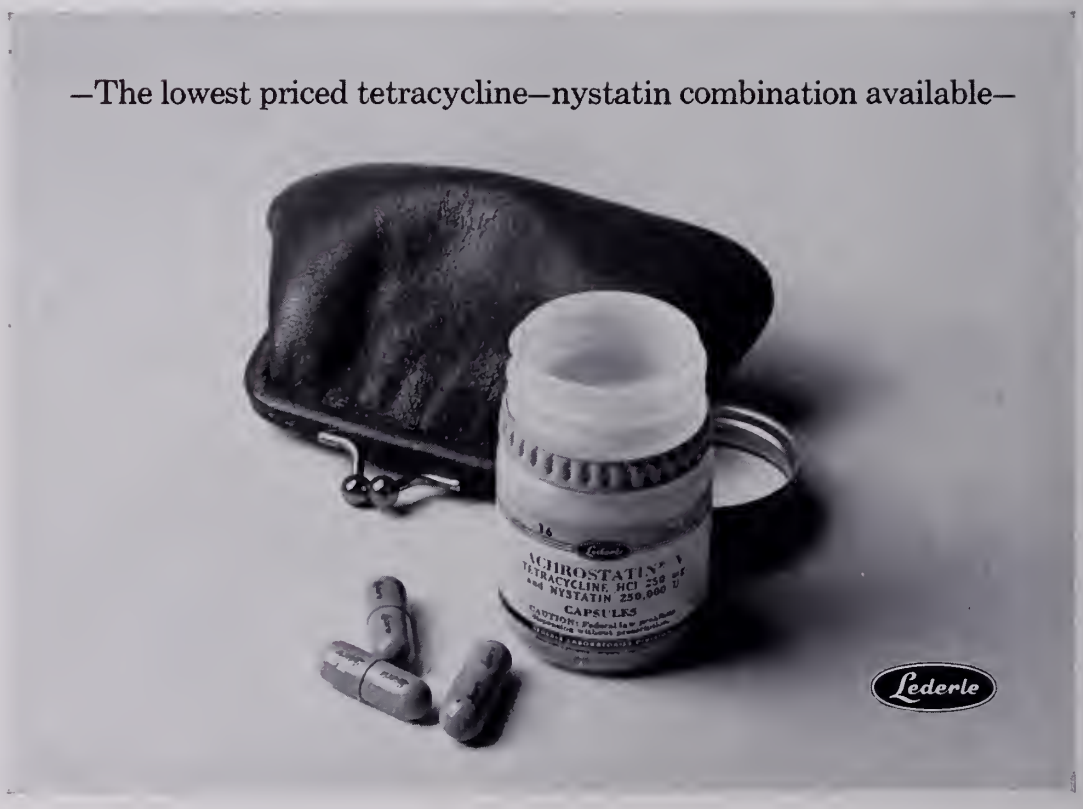
KMA Educational Television Committee

Thomas L. Heavern, Jr., M.D., Highland Heights, Chairman

University of Kentucky Medical Center **May 19, 1970**

The KMA Educational Television Committee traveled to Lexington on May 19 to hold their fifth meeting of the Associational year. Discussion included a review of potential funding sources and plans for coordinating next year's PANMED series which will be shown over Kentucky Educational Television in October.

A major part of the meeting was spent reviewing programs to determine those which will be included in future program scheduling. The committee also finalized arrangements to "re-run" the initial series over the KET Network during the summer months. The re-runs will begin on June 3 and will be shown every Wednesday evening at 9:30 p.m.



(Continued from page 442)

8. Buschke, F. and Vaeth, J. M.: Radiation Therapy of Carcinoma of the Vocal Cord Without Mucosal Reaction, *Am. J. Roentgen.* 89: 29-34: 1963.
9. Baclesse, F.: Clinical Experience with Ultrafractionated Roentgentherapy, *Progress in Radiation Therapy,* Edited by Buschke, F. Grune and Stratton, New York, 1958, pp. 128-143.
10. Cantril, S. T.: Radiation Therapy in Cancer of Larynx: A Review. *Am. J. Roentgen.,* 81: 456-474: 1959.
11. Lederman, M.: Place de la Radiotherapie dans le Tritement du Cancer du Larynx. *Ann. de Radiol.* 4:433-454, 1961.
12. Baclesse, F.: Carcinoma of the Larynx—*British J. Rad. Suppl.* 3, 1949.
13. Fletcher, G. H. and Klein, R.: Dose Time Relationship in Squamous Cell Carcinoma of the Larynx. *Radiology,* 82 : 1032 : 1964.
14. Nielsen, J.: Functional Results and Permanence of Cure Following Roentgentherapy in Intralaryngeal Carcinomas, *J. Fasc. Radiol.,* 3 : 145 : 1962.
15. Wang, C. C. and Schulz, M. D.—Cancer of the Larynx, *Radiology,* 80 : 963 : 1963.
16. Alonso, J. M.: Conservation of Function in Surgery of Cancer of the Larynx: Bases, Technics and Results, Trans. *Am. Acad. Ophthal. Otolaryngol.* 56 : 722 : 1952.
17. Leroux Robert, J. Formes Anatomo-Cliniques et Indications Therapeutiques des Epitheliomas Intralarynges. *Ann. d' Oto-Laryng.* 11 : 1003 - 1044 : 1937.
18. Szlezak, L. (Medical Academy, Poznan, Poland) — Histological Serial Block Examination of 57 Cases of Laryngeal Cancer: Morphological and Clinical Correlations. *Oncologia,* 20 : 178 - 194 : 1966.
19. Norris, Ch. M.—Treatment of Cancer of the Larynx and the Hypopharynx. Fifth National Cancer Conference Proceedings, J. B. Lippincott Co. pp. 265, 1964.
20. McGavran, M. H., Bauer, W. C. and Ogura, J. H.: The Incidence of Lymph Node Metastasis From Epidermoid of the Larynx and Their Relationship to Certain Characteristics of the Primary Tumor, *Cancer* 14 : 55 - 66, 1961.
21. Kuhn, A. J., Devine, K. D, McDonald, J. R.— Cervical Metastasis from Squamous Cell Carcinoma of the Larynx, *Laryngoscopy* 67 : 169 - 190: 1957.
22. Moss, W. T. and Brand, W. N.: Therapeutic Radiology— C. V. Mosby Co. pp. 169, 1969.
23. Perez, C. A., Holtz, S., Ogura, J. H., Dedo, H. H. and Powers, W. E.: Radiation Therapy of Early Carcinoma of the True Vocal Cords, *Cancer,* 21 : 764 - 771: 1968.
24. Hendrickson, F. R.: Radiation Therapy in Mouth and Larynx Cancer, Fifth National Cancer Conference Proceedings, J. B. Lippincott Co., pp. 271, 1964.
25. Wang, C. C. and O'Donnell, A. R : Cancer of the Larynx. Five Years Results After X-ray Therapy, *New England J. Med.* 255 : 1033-1035 : 1955.
26. Goldman, J. L., Cheron, R. V., Zak, F. G. and Gunsberg. M. J.: Histopathology of Larynges and Radical Neck Specimens: In Combined Radiation and Surgery Program for Advanced Carcinoma of the Larynx and Laryngopharynx. *Ann. Otol., Rhin. and Laryng.* 75 : 313 - 336 : June, 1966.
27. Baker, H. W.: Surgical Management of Recurrent Laryngeal Cancer after Irradiation. *Cancer* 16 : 774 : 1963.
28. Ditchek, T. and Lampe, I.: Radical Surgery After Intensive High Energy Irradiation. *Arch. Surg.* 86 : 534-539 : 1963.
29. Robbins, R.: Indications for Radiation Therapy in Laryngeal Cancer, *Am. J. Roentgen.,* 83 : 21 - 24 : 1960.
30. Fnnvayer, A., and Bataini, P.: Treatment of Supraglottic Carcinomas by Telecobalt Therapy, *Brit. J. Radiol.* 38 : 661 - 666: 1965.
31. Lampe, I.: Radiotherapy of Carcinoma of the Larynx. Proceedings of the Third National Cancer Conference, Philadelphia, 1957, J. B. Lippincott Co.
32. Lederman, M.: Place of Radiotherapy in Treatment of Cancer of the Larynx. *Brit. Med. J.* 1 : 1639 - 1646 : 1961.
33. Leroux Robert, J.: La Chirurgie Seule et L'Association Chirurgie—Radiotherapie dans le Traitment des Epitheliomas du Larynx et de L'hypopharynx. *Ann. d'Oto-Laryng.,* 67 : 217 - 266 : 1950.
34. Leroux Robert, Jr. and Ennvayer, A.: Resultats de L'Association Chirurgie - Roentgentherapie ov de 'la Chirurgie Suele dans les Epitheliomas du Larynx. *Ann. d'Oto-Laryng.* 73 : 521 - 545, 1956.
35. McComb, W. S. and Fletcher, G. H.: *Policy of Treatment—Cancer of the Larynx.* University of Texas M.D. Anderson Hospital and Tumor Institute, Houston, 1957.
36. Baclesse, F.: Roentgentherapy in Carcinoma of the Larynx. *J. Fac. Radiol.* 3 : 239 : 1952.
37. Powers, W. E.: *Cancer Therapy by Integrated Radiation and Operation.* pp. 3 - 12 - Charles C. Thomas, Springfield, Illinois.
38. Powers, W. E. and Palmer: Biologic Basis of Pre-Operative Radiation Treatment. *Am. J. Roentgen,* 102 : 176 - 192, 1968.
39. Bloedorn, F.: *Radiation and Surgery — In Progress in Radiation Therapy,* F. Buschke, pp. 114, Gruñe and Stratton, 1962.
40. Henschke, V., Frazell, E., Hilaris, B., Nickson, J., Tollefsen, H., and Strong, E.: Local Recurrences after Radial Neck Dissection with and without Pre-operative X-ray Therapy. *Radiology,* 82 : 331 - 332 : 1964
41. Henschke, V. K., Frazell, E. L., Hilaris, B. S., Nickson, J. J., Tollersen, H. R. and Strong, E. W.: Value of Pre-operative X-ray Therapy as an Adjunct to Radical Neck Dissection. *Radiology,* 86 : 450, 1966.
42. Biller, H. F., Ogura, J. H., Davis, W. H., Powers, W. E.: American Laryngological, Rhinological and Otogical Society Annual Meeting. *JAMA,* 208, No. 4, April, 1969.
43. Goldman, L. G., Silverstone, S. M., Rosin, H. D., Cheren, R. V. and Zak, F. G.: Combined Radiation and Surgical Therapy for Cancer of the Larynx and Laryngopharynx II. *Laryngoscope* 1111 - 1134: 1964.
44. McGavran, M., Ogura, J. and Powers, W. E.; Small Dose Pre-operative Radiation Therapy. *Radiology,* 83 : 509 - 519 : 1964.
45. Hendrickson, F. R., Liebner, E.: Results of Pre-operative Radiotherapy for Supraglottic Larynx Cancer. *Ann. Otol. Rhin. and Laryng.* 77 : 222 -229: April, 1968.
46. Reed, G. F.: Pre-operative Irradiation in Laryngeal Carcinoma. *Arch. Otolaryng.* 86 : 318-325: Sept., 1967.
47. Lindberg, R., Jesse, R. H.: Treatment of Cervical Lymph Node Metastasis from Primary Lesions of Oropharynx, Supraglottic Larynx and Hypopharynx. *Am. J. Roentgen.* 102 : 132 - 137 : 1968.
48. Catlin, D. and Strong, E. W.: Pre-operative Irradiation for Neck Dissection. *S. Clin. North America,* 47 : 1131 - 1137 : Oct., 1967.

Legislation Proposed To Change National Medicare Program

The House Ways and Means Committee recently approved legislation that would change the medicare program to permit prepaid closed-panel group practice care and would set ceilings on physicians' fees under medicare and medicaid.

Among the recommendations concerning Medicare and Medicaid, the Committee suggested these major changes:

Part A for Ineligible Aged. This would permit those over 65 who are otherwise ineligible for Medicare benefits to enroll in the Part A program by paying the total premium, at the initial rate of $27 per month.

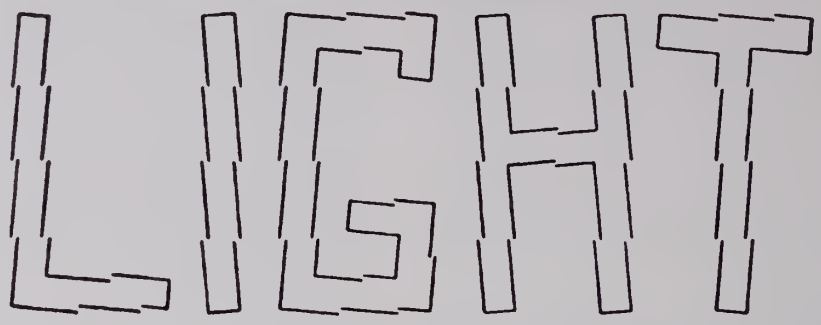
Health Maintenance Organization Option. Individuals eligible for Medicare benefits could choose to have their care provided by a Health Maintenance Organization (a prepaid group health or other capitation plan). The government would reimburse the health organization on a capitation basis not to exceed 95 per cent of the cost of Medicare benefits provided the beneficiaries in the area not covered under the Health Maintenance Organization.

Limitations on Recognition of Physician Fee Increases. Physician charges under Titles 5, 18, 19 of the Social Security Act would be limited by providing that during fiscal 1971, medical charge levels recognized as prevailing could not be increased beyond the 75 percentile of actual charges in a locality during calendar year 1969.

Termination of Payments to Providers. The Secretary of HEW could terminate payment for services rendered by a supplier of health and medical services deemed to be guilty of program abuses. Program review teams would be established to furnish the Secretary professional advice in carrying out this authority.

Chiropractic Services. The Department of HEW would conduct a study covering chiropractic service "on a very limited basis" under Medicare utilizing the experimental authority under the Medicaid program. The report of the study would have to be submitted to the Congress within two years.

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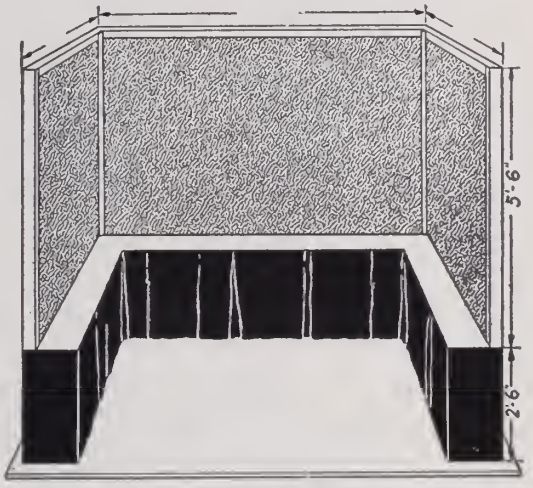
Convention Center — **Louisville, Kentucky** — **September 22, 23, 24**

Fill Out and Mail to:

T. R. MARSHALL, M.D., Chairman
Committee on Scientific Exhibits
Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, Kentucky 40205

Applications for space should be received before July 1, 1970

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....
   Institution (if desired): .....
   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)
   Charts and Posters.... Photographs.... Drawings.... X-rays ....
   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
   Amount of total wall space needed? .....
   Back wall ..... Side walls (All side walls are 4') .....
   Square feet needed? ..... Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided to you in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....
Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

KENTUCKY MEDICAL ASSOCIATION

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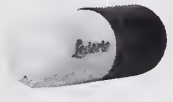
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abscess
acne
amebiasis
anthrax
bacillary dysentery
bartonellosis
bronchitis
bronchopulmonary infection
brucellosis
chancroid
diphtheria
endocarditis
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gonorrhea
granuloma inguinale
listeriosis
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mixed bacterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
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pyelonephritis
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scarlet fever
septicemias
sinusitis
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tonsillitis
tularemia
typhus fever
urethritis

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Every pharmacist knows ACHRO® V stands for ACHROMYCIN® V

Contraindications: Hypersensitivity to tetracycline.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

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Adverse Reactions: Drowsiness, otoxio ond confusion moy occur, especiolly in the elderly and debilitoted. These ore reversible in most instances by proper dosoge odjustment, but ore olso occosionolly observed ot the lower dosoge ronges. In o few instances syncope hos been reported. Also encountered ore isoloted instonces of skin eruptions, edemo, minor menstrual irregulorities, nousea ond constipation, extropyromidol symptoms, increosed ond decreosed libido—oll infrequent ond generolly controlled with dosoge reduction; chonges in EEG potterns (low-voltoge fost octivity) moy oppeor during ond ofter treotment; blood dyscrosios (including ogronulocytosis), jaundice ond hepotic dysfunction have been reported occosionally, moking periodic blood counts ond liver function tests odvisoble during protrocted theropy.

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VOLUME 68 AUGUST 1970 NUMBER 8

The Journal of The KENTUCKY Medical Association

Annual Meeting Issue



AUG 17 1970

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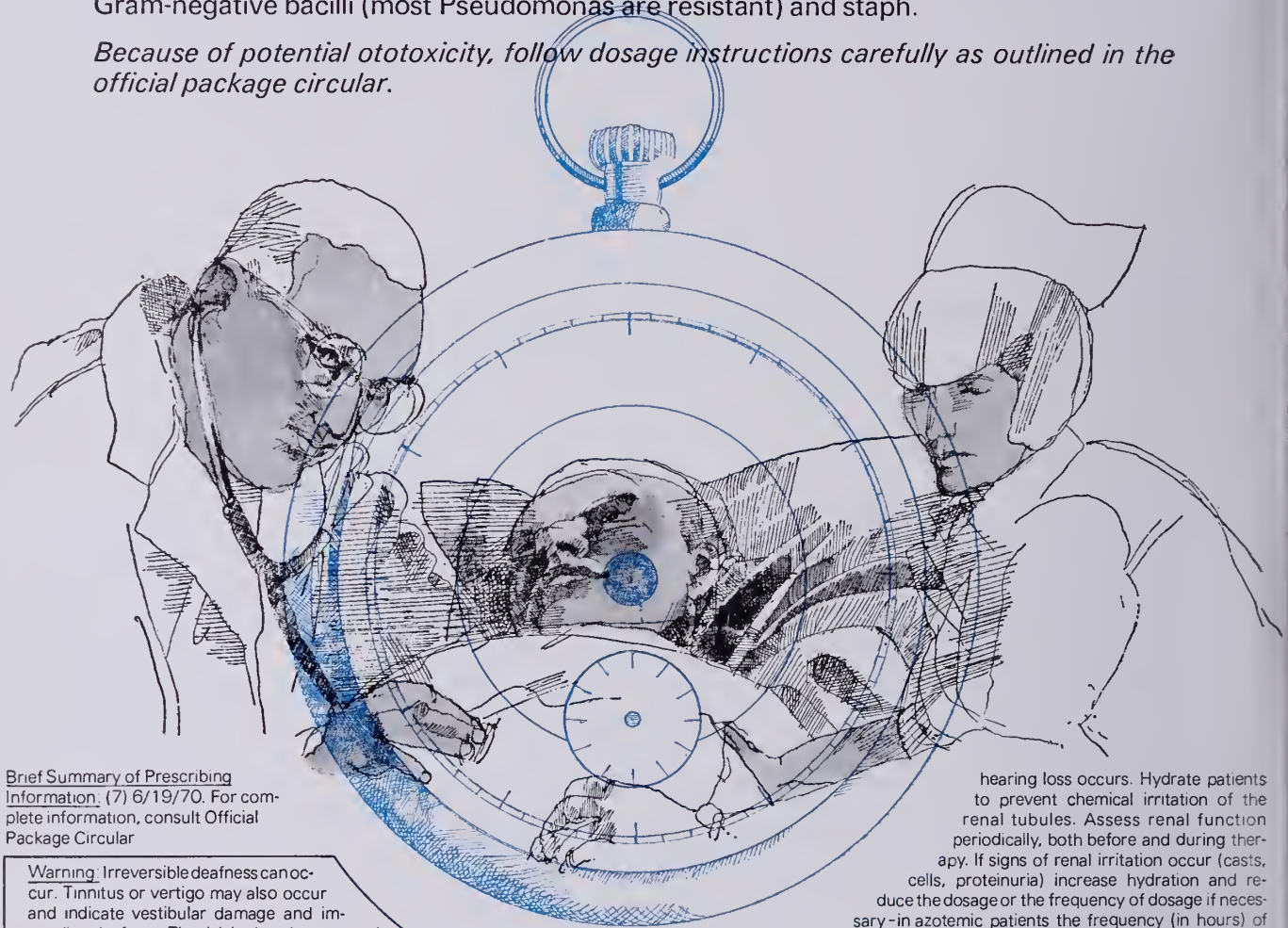
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A valuable hospital antibiotic —when there is no time

in severe systemic infections—postoperative bacteremia, Gram-negative/staph pneumonias or neonatal sepsis—Kantrex® (kanamycin sulfate) is often indicated before results of customary sensitivity tests can be reported. Clinical response is often seen within 24-48 hours in susceptible infections, with remission soon after.

10 years of experience confirm the continuing effectiveness of Kantrex® against many Gram-negative bacilli (most Pseudomonas are resistant) and staph.

Because of potential ototoxicity, follow dosage instructions carefully as outlined in the official package circular.



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Warning: Irreversible deafness can occur. Tinnitus or vertigo may also occur and indicate vestibular damage and impending deafness. The risk is sharply increased with renal dysfunction. In such cases, decrease size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. Watch carefully for ototoxicity in older patients and patients receiving more than 15 Gm. of kanamycin. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in post-operative patients until recovery from anesthesia and muscle relaxants is complete. Avoid concurrent use of other ototoxic drugs including ethacrynic acid. Safety in pregnancy is not established.

Indications: Serious infections due to susceptible strains of *E. coli*, Proteus sp., *A. aerogenes, K. pneumoniae, Serratia marcescens* and *Mima-Herellea*. Culture and sensitivity studies should be performed.

Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.

Precautions: Obtain audiograms before and during therapy in patients with renal dysfunction when treatment lasts more than 5 days. Stop Kantrex if tinnitus or hearing loss occurs. Hydrate patients to prevent chemical irritation of the renal tubules. Assess renal function periodically, both before and during therapy. If signs of renal irritation occur (casts, cells, proteinuria) increase hydration and reduce the dosage or the frequency of dosage if necessary - in azotemic patients the frequency (in hours) of doses may be obtained by multiplying the serum creatinine by 9. If azotemia or oliguria occur, discontinue therapy. Mycotic or bacterial superinfection may occur.

Adverse Reactions: Irritation or pain at the injection site, skin rash, drug fever, headache and paresthesias.

Dosage and Administration: The maximum total daily dose should not exceed 1.5 Gm. by all routes of administration. The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gm. daily. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 3 to 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours. The drug should not be physically mixed with other antimicrobials.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. and 1.0 Gm. in 3 ml. Also available—Pediatric Injection 75 mg. in 2 ml. A.H.F.S. Category B.12.28

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(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

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Louisville, Ky. 40205
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Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

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A urinary tract infection was eliminated last week

estinal monilial overgrowth has appeared this week

For women who are diabetic or debilitated, oral antibiotic therapy often sets the stage for monilial overgrowth in the intestine.

When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

It doesn't let monilia begin where bacteria end. Declostatin® 300

Demethylchlortetracycline HCl 300 mg and
Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

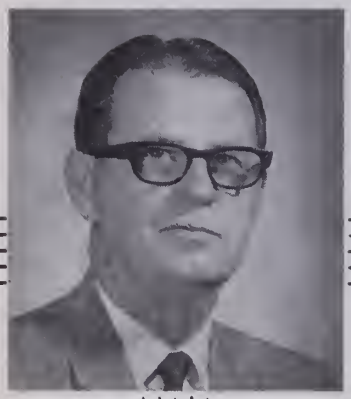
Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MESSAGE FROM THE PRESIDENT



1970 AMA Annual Convention

Thorough preparation made this AMA Annual Convention an uninterrupted one. For the first time in the AMA history, the House of Delegates appointed a special reference committee to hold a public forum for consumers and representatives of groups to present their thoughts on medical and health care. I heard three hours of statements on Sunday afternoon. Many of the consumer suggestions concerned AMA programs that are already established and doing well. The committee recommended to the AMA Board of Trustees that consideration be given to an open consumer's forum at each AMA Annual and Clinical Convention.

Much debate occurred before the reference committee and in the House concerning AMA's policy on therapeutic abortion for only five specific reasons. Under the new AMA policy, abortion is deemed "a medical procedure to be performed by licensed physicians in an accredited hospital and only after consultation with two other physicians chosen for their professional competence." It was specifically spelled out that "no person or institution can be required to perform an abortion." The policy statement says that an M.D. may "withdraw from a case so long as the withdrawal is consistent with good medical practice." I further specified that "neither physician, hospital nor hospital personnel shall be required to perform any act violative of personally held moral principles."

Last, but not least, I want to comment briefly on the efforts of all Kentucky physicians on our desire to elect Robert C. Long, M.D., as President-Elect of the American Medical Association. All of us who had an opportunity to attend the convention felt that we had the best candidate. The work done by members of the KMA and its many friends was highly commendable. Our loss of the presidential bid on the third and final ballot did not erase a very deep and lasting impression made by the fine Kentucky delegation on all in attendance at the AMA meeting. In our minds Bob remains the best candidate. One could think that he now has more time to devote to his great loves, his family and the practice of medicine. It is my prediction that he will continue in the high ranks of leadership. KMA is justly proud of Bob, a highly respected and capable member, and his fine family.

Walter L. Cawood



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Brief Summary of Prescribing Information—9-9/22/69. For complete information consult Official Package Circular.

Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

Usual Dose: 1 tablet b.i.d.

Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

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The antihypertensive therapy that is easy to live with.*

When successive blood pressure readings confirm essential hypertension, consider Salutensin for:

Easy-to-live-with control. Gradual reduction of blood pressure leading to decisive, comfortable control is the common clinical response.

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Easy-to-live with dosage. Two tablets a day usually achieves control. One to two tablets a day often maintains control without need for additional antihypertensive agents.

Easy-to-live with cost of therapy. The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.



From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 1-69. This 22-year-old married white gravida 2, para 1, had prenatal care during the first two trimesters of this pregnancy in another state. No problems were encountered.

She was seen on three occasions from 1/8/69 to 2/12/69. Weight gain was 24 pounds. Her blood pressure on the last clinic visit, 2/12/69, was 120/80 with a trace of proteinuria.

At 2 p.m. on February 23, 1969, at 38 weeks gestation, she fainted or fell as she left church. At 3:55 p.m. she was seen by a physician, unconscious, in a morbid state. She was chewing her tongue and was described as in "status epilepsy." Blood pressure was 160/100. An attempt was made to get her mouth open sufficiently to establish an airway. However, this could not be done. Oxygen was administered. Her position was shifted after giving 10 cc of 50 per cent Magnesium sulfate IM, 5 Gr Phenobarbital IV at 3:55 p.m. At 4:10 p.m. another 4 Gr of Phenobarbital IV was given before she was referred back to the clinic where she had been receiving prenatal care.

She arrived in the emergency room of the hospital at 5:13 p.m., cyanotic, comatose, with a poor airway. No blood pressure or fetal heart tones were audible. Before an adequate airway could be established, cardiac arrest occurred. She responded to cardiac massage, but failed to maintain perfusion despite administration of $NaHCO_3$, calcium, vasopressors and transcutaneous cardiac pacemaker. She expired at 6:40 p.m. Post mortem examination was refused.

The clinical impression was cardiac arrest secondary to airway obstruction presumably due to eclampsia.

Comment

This case was considered to have preventable factors that contributed to the patient's death. Although the etiology of her convulsions cannot be established since post mortem examination was refused, the Committee indicated that a proper airway should have been established by an endotracheal tube or tracheotomy. The wisdom of transporting such a patient a long distance was questioned. It would appear that the clinical impression was correct that death was due to anoxia secondary to airway obstruction. Perhaps closer attention to and treatment of the blood pressure of 120/80 and trace of proteinuria should have been carried out on the clinic visit of 2/12/69. At this stage of gestation (38 weeks) she should have been seen weekly.

From the information available, the cause of the convulsions could have been eclampsia, a cerebral vascular accident or massive pulmonary embolus. Since the patient had not been seen by a physician for 11 days, eclampsia is a good possibility. Cerebral vascular accident accounts for a large number of maternal deaths. Barnes and Abbott[1] found that in 170 maternal deaths, 36 were caused by cerebral complications. Inman and Vessey[2] report a mortality rate of 0.2/100,000 women in this age group due to thromboembolic disease.

References

1. Barnes, J. L. and Abbott, K. H.: *California Med.* 91:237, 1959.

2. Inman, W. H. W. and Vessey, M. P.: *Brit. Med. J.* 2:193, 1968.

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See Clinical Considerations section on last page...

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Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	Resistant/ Moderately Severe	Serious/Life-Threatening
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

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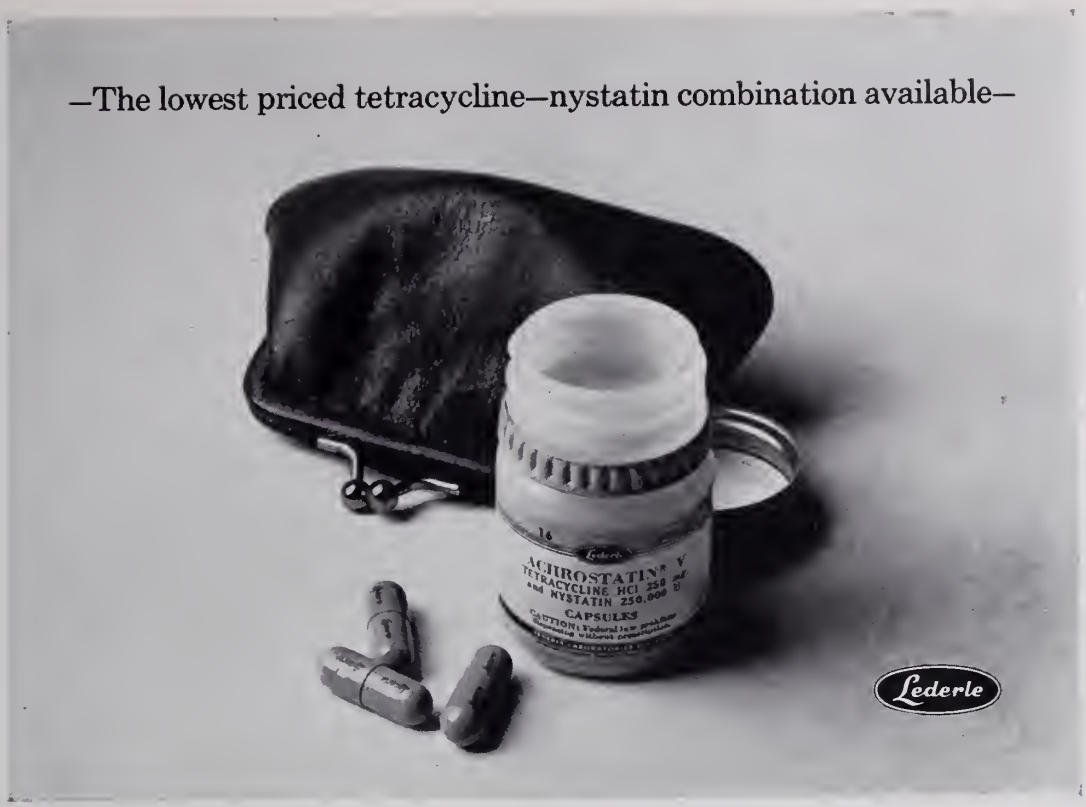
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Issued Monthly Under The Direction Of The Board Of Trustees

VOLUME 68 AUGUST 1970 No. 8

Snake Bite!

Robert E. Arnold, M.D.

Louisville, Kentucky

REPTILES have always been mysterious, fascinating members of the animal kingdom. From the days of Eve to the Seminole Indians of today they have been venerated, worshiped, and believed to be possessed by evil spirits. They have been utilized as instruments of suicide, homicide and executions. The Seminole Indians of Florida will not permit a snake to be killed because of their religious beliefs. The morbid fascination for these simple animals extends to the medical profession whose early practitioners emblazoned the twin serpents on the caduceus.

Many myths have arisen concerning these reptiles. These characteristics would appear to be almost human to the casual observer. Realistically, they are very simple animals, and spend their entire life in search of food, escaping danger and mating. They are quite timid and unlikely to fight any animal unless threatened and this is done in self defense. Their actions are instinctive rather than premeditated. The following myths are popular but have no basis in fact.

Hunters Most Often Bitten: A popular misconception is that hunters are often bitten by snakes. The fact is most victims are bitten at home. Most victims are children who are careless or ignore dangerous areas. Four of the five fatalities recorded in Kentucky in the last 10 years were involved with the use of snakes in religious exercises.

Snakes Travel in Pairs: The advice to look out for the mate of a reptile is not a reason to poke around in underbrush or shrubbery. The fact is that several snakes may be in the same area, this being directly related to the food supply and not to filial loyalty.

Rattle Snakes Warn Before Striking: They do not always warn intruders by rattling before striking. They do not strike when above ground as in shrubberies, small trees, etc.

Snakes Stalk Victims: Contrary to widely held beliefs it appears improbable that snakes ever stalk a victim. The usual story is that of accidentally stepping on a snake, children picking one up or fishermen dangling their catch over the side of the boat.

Venomous Snakes: Venomous snakes in the United States are all members of the *Crotalidae* or pit viper family, or the *Elapidae* or Coral snakes. The pit viper family includes the rattle snakes, moccasins and copperheads. They are found in practically all the 48 continental states.

There are approximately 25 different species of snakes, at least four moccasins, and three copperheads. Kentucky is the native habitat to two rattle snakes, two copperheads, one aquatic moccasin and two dry land moccasins. Mortality and morbidity is almost entirely limited to the two rattle snakes and the aquatic moccasin.

The strike of a pit viper is the mechanism for introducing the venom into the prey. The jaws are opened, the hollow fangs erected and the forceful driving forward of the head ensues. Penetration of the fangs is followed by a con-

traction of the jaw muscles which encloses the venom gland and injection of the venom results. The head is then quickly withdrawn for protection. Any poisonous snake can strike with accuracy one half of its length. The pits are heat sensitive locaters which enable the snake to keep directed on the prey[1].

Venom

The venom produced by the reptile is a feeding rather than a defensive mechanism. Snakes rely for defense on coloration and a lack of natural enemies. The venom is a "Prehensile" complex which secures, kills and digests the prey. Venom is peculiar in that it is most effective against rodents, rabbits, frogs, etc., which die almost immediately. The prey is then ingested whole and the injected venom completes the digestion. Envenomation in other animals, however, is extremely varied The venom has been shown to have the following effects: neurotoxic, hemorrhagic, thrombogenic, hemolytic, proteolytic, antifibrin, anticoagulant and antibactericidal, and ferments and kinases for digestion[2].

A very potent spreading factor is also present. Envenomation in humans commonly exhibits the following effects:

1. A neurotoxic effect
2. Spreading effect
3. Digestive effect
4. A hemorrhagic effect

These four factors mentioned above are present in varying amounts in each species of pit viper. The venom is particularly adapted to kill the usual animal used for food. Immediately, death follows envenomation in these animals. The animal is then swallowed whole and the digestive factors continue to break down protein, etc. Crotalus Adamantheus (Eastern Diamondback) venom has the highest concentration of digestive factors[3]. Crotalus Scutulatus Scutulatus (The Mojave Rattle Snake) has the highest concentration of neurotoxic factor[4]. The spreading factor is present in all venoms. The digestive factor causes more morbidity in humans than the neurotoxic factor.

Local reaction of loss of limb is caused from digestion of muscle with resultant edema. This edema causes a marked increase in the subfascial tension great enough to occlude arterial blood flow with subsequent gangrene of the extremity.

Systemic reaction to crotalus envenomation is extremely variable, even with the same species of snake. Deaths have been reported from hemorrhage in bowel and bladder or subcutaneous, intraperitoneal, and intrathoracic hemorrhage; in others, neurotoxic features such as fasciculation, immediate, severe, generalized weakness and painful cramps are dominant. A third important factor is the presence of denatured protein, blood, etc. in the extremity secondary to protein digestion. These elements lead to shock, renal and hepatic shut down and myocardial failure.

Although more people in the world die from snake bite than all other animals combined,[5] in the United States loss of limbs, rather than death, is the usual criteria of unsuccessful treatment. Ninety eight per cent of bites are located on extremities[6]. Limb loss seems to be more common in children who for some reason seem to be more sensitive to snake venom than adults.

Symptoms

Pain and swelling of the envenomated limb are almost always present. Fang marks must be present also. Weakness, nausea, vomiting, vertigo, numbness, fasciculation, cramps and tingling have been described. Yellow vision and blindness due to retinal hemorrhage occur. Signs of shock may appear early, also blood or blood-tinged excretions from all body orifices, with convulsions, coma and death. The symptoms have been graded 0 to IV and the grades are well defined and offer the practitioner a guide to therapy. (Table I.)

Treatment

Emergency treatment or initial treatment given by lay persons usually at the site of accident should have two objectives: 1) limit the spread of venom and 2) get the patient to a hospital and a doctor as soon as possible! Many schemes including suction, incision, tourniquet, cooling, etc. have been recommended. Although some of the procedures are valuable, they contain inherent dangers and should not be used in a setting other than a hospital. Valuable time should not be spent searching for the snake, as this has no practical benefit. The antivenin used is the same

for all pit vipers and treatment will depend on the previously mentioned grading. Limitation of spread of venom can very simply and effeetively be aecomplished by splinting the extremity, and keeping general body museular aetivity to a minimum[7]. Experiments with radioaetive tagged venom showed that there is only a 22 per eent spread of venom in one hour if the limb is splinted, and this should be time to get to a hospital and get more definitive treatment[8]. The patient should be carried to the hospital if possible. This will reduce general body museular aetivity A generally reassuring attitude on the part of the first-aider is also very beneficial.

Hospital Treatment

Administered by a physieian after arrival to the emergency room, should be the following hospital treatment:

1. Look for fang marks!

There are no poisonous snakes without fangs and likewise no harmless snakes with fangs.

2. Grade the bite—Use the table, grade from 0 to IV. The time of envenomation should be available.

3. Start an I.V. in the eontralateral arm with a needle large enough to administer blood. Draw enough blood at the same time for a ebe and a type and eross mateh. Many times blood tranfusions are required and if the physieian delays too long in obtaining a type and eross match, it may be impossible to eross mateh the blood. Have blood available.

4. Skin test for antivenin sensitivity. This could be done while the I.V. is being started. Use the following regime for a mild to moderate envenomation, that is; grade 0, 1, III.

5. Add the appropriate amount of antivenin to the I.V. fluids whieh have already been started. The I.V. should be running at a rate to deliver the antivenin in three to four hours. *Do not give* intramuseular antivenin. Desensitization may be neeessary prior to giving the antivenin if the skin test is positive.

6. Start on broad speetrum antibioties.

7. Tetanus prophylaxis.

8. Enlarge the fang marks—make 2 mm. incisions transversely at either side of fang marks.

9. Control pain—this can very simply be done in this case with Demerol, Morphine, ete.

10. Keep the patient NPO.

11. Very important—Cheek the eireulation distal to the bite at least every hour. The inerease in subfaseial tension may oeclude ar-

Table I

Grades and Treatment of Envenomation

Severity		Number of Vials of Antiven'n
0.	Fang marks—no envenomation: Reveals 1" wheal or less in the first 12 hours	0
I.	Mild envenomation:	1-2
II.	Moderate envenomation: Severe pain, tenderness, edema extending 10"-15" within 12 hours, erythema, petechiae, ecchymosis, weakness, nausea, vomiting, bloody ooze at the fang marks	2-5
		Moderate (86% of all bites)
		Severe (14% of all bites)
III.	Severe envenomation: Widespread pain, tenderness, edema extending 10"-20" within 12 hours, petechiae, ecchymosis, weakness, nausea, vertigo and vomiting appearing rapidly	5-10
IV.	Very severe envenomation: Rapid swelling, may affect ipsilateral trunk, ecchymosis, bleb formation, weakness, vertigo, vomiting, hematemesis, tingling about face and head, fasciculation, muscle cramping possible paralysis, yellow vision, blindness, shock, convulsions.	10-30

From: Arnold, E. M.D. and Gennaro, Joseph, Ph. D.: "Treatment of Poisonous Snake Bite in the United States," KAGP Journal, Vol. 15, No. 1, Page 11, January 1969.

terial flow and subsequent gangrene of the extremity distal to the bite may occur.

12. Check vital signs hourly; also check urine for blood.

Severe Envenomation Grade III or IV: The initial four steps remain the same:

5. Add the appropriate amount of antivenin to the I.V. Put at least one half the amount of calculated antivenin necessary for the particular grade in the initial I.V. to run in, in three or four hours. The total amount of antivenin should then be followed I.V. within the first 24 hours of being bitten.

6. Excise the bite if patient is seen within 60 minutes of being bitten. (Experiments with tagged venom show that 50 per cent of venom can be removed this way if it is done before one hour passes.)

Procedure

Make elliptical incisions one inch equidistant from the fang marks to the depth of the fangs. Remove an elliptical "plug" of tissue thus outlined, preserving vital structures. Put a wet dressing on the wound and leave open. This may be closed secondarily later or skin grafted.

7. Use axillary block or spinal anesthesia for relief of pain. This has the added advantage of sympathetic block and increasing blood supply to the extremity.

8. A tourniquet may be used above the edematous area only if it appears that this is a catastrophic event. Recent experiments show that the venom which is incarcerated in the extremity may do more damage to the extremity[9]. Also, deaths have been reported when the tourniquet is removed and a large bolus of digested protein, blood and venom suddenly is released in the systemic circulation.

Prior to removal of the tourniquet, antivenin should be circulating at least 30 to 60 minutes. The extremity distal to the tourniquet should be drained of blood as well as possible with a needle in the vein. The tourniquet should occlude the venous return but not arterial supply—thus a crude perfusion is possible. Use of a tourniquet may aid in saving a life with concomitant increase in danger to the limb.

9. Check distal circulation. Fasciotomy may be necessary if the arterial circulation becomes occluded. This usually happens at the wrist and ankles. Transverse incisions should be made in the skin and vertical incisions in the fascia. This allows relief of the pressure but has sort of a grid iron effect to keep the muscles from herniating through and sloughing. Incisions in the same plane are contraindicated as the subfascial pressure is so great that there will be a large extravasation of muscle and tissue with subsequent loss.

10. Maintain blood pressure and pulse, insert a Foley Catheter and check the urine for volume and blood. Be prepared to maintain respiration and blood volume.

11. Tetanus Prophylaxis and broad spectrum antibiotics.

Incision and Suction

I am mentioning incision and suction separately because of its wide use. There is no doubt but that venom can be sucked from the fang punctures. The fang marks should be enlarged about two to three millimeters on each side and a constant (not mouth) suction applied. If suction is started early and the bite is subcutaneous, about 50 per cent of the venom may be removed in this manner. Suction after 30 minutes of elapsed time from being bitten is valueless. Valuable time should not be lost in making these incisions and starting the suction as a first aid measure. A bad situation may become desperate in a short time. Vital structures may inadvertently be damaged, ulnar nerve, median nerve, etc. Incising an unanesthetized painful wound by an inexperienced person in an extremely stressful situation may make the patient more nervous, hyperactive and enhance the spread while transporting to a hospital would, of course, be beneficial.

Incision and suction in a hospital setting with a physician is a safe procedure. It is however ineffective 30 minutes after being bitten. It is probably not necessary in cases of mild envenomation and with severe envenomation excision of the bite is a more effective means of removal of venom. Suction may be beneficial in a grade II or III situation if started soon enough. Suction is at best an adjunct of definitive treatment and not a fundamental procedure.

The use of intra-arterial antivenin and isolation perfusion techniques should be men-

tioned here. It is very unlikely that these techniques would be necessary in this country. However, they are available and in a catastrophic event may be utilized. Snyder reported cases of arterial infusion of antivenin[8]. He utilized the carotid artery for bites on the head and the femoral artery and brachial arteries for bites on the extremity. Unfortunately, he did not grade the bites so it was impossible to tell how severe the envenomation was. The procedure was merely adding antivenin to I.V. fluids and pumping these into the artery using a needle and a regular bulb pump. Experimental work on dogs indicate that an isolation perfusion system, in which an occlusive tourniquet is used above the bite and the antivenin pumped into the artery and the appropriate vein is drained, is probably the most effective treatment.

Extremely good results have been obtained with dogs[11] but I can find no instances where it has been used on human beings. This treatment is fairly difficult and extreme and would probably be of more value in South America, Africa, etc.

Most Common Errors

Not enough antivenin—careful scrutiny of charts of fatal cases reveal a reluctance on the part of the physician to use adequate amounts of antivenin. (15 to 30 vials) At least half of the antivenin should be given in the first few hours or so and the total amount within the first 24 hours.

Antivenin given I.M. instead of I.V.—fatal case reports many times indicate the antivenin was given I.M., Sub Q, etc., due to a reluctance on the part of the physician to give large amounts of I.V. horse serum. Tagged antivenin studies show 84.9 per cent of the antivenin localized at the site of envenomation two hours after I.V. administration. This is contrasted with intramuscular administration which results in 1.43 per cent at the site and subscapular injection which resulted in 5.6 per cent of the dose in the envenomated leg in two hours[9].

Keep a syringe of adrenalin loaded in case of anaphylaxis. Shut off the antivenin drip and inject adrenalin in case of an anaphylactic reaction. *Do not use Antihistamines.* These have a synergistic action with the venom and are contraindicated. Do not use cortisone. Cortisone evidently interferes with the antigen-antibody reaction between the venom and antivenin. Both have been shown to have no benefit whatsoever[7]. Alcohol is contraindicated as it has no beneficial effect, is a depressant and enhances the spread of venom.

Do not use the tourniquet ice treatment unless the decision has been made to sacrifice the limb at a later date in order to save a life. This was a very popular form of therapy advocated in 1950. This form of treatment was reproduced in *Arizona Highways* and several other lay magazines. The simplicity was so appealing that it gained immediate acceptance. Many unnecessary amputations have resulted from this and I am mentioning this treatment only to condemn it unless amputation is a foregone conclusion. In this event, an operative permit signed for an amputation of the limb must be obtained before treatment is started.

Coral Snakes

Coral snakes belong to the Elapidae family. The Eastern Coral snake, Micrurus Fulvuis Fulvuis, the South Florida Coral M.F. Barbouri, are found in Florida, Alabama, South Carolina and North Carolina. It is claimed that they are found as far north as Tennessee and Kentucky. The Texas Coral or M.F. Tenere is found in southwest Arkansas, Louisiana, Texas to Mexico. The Arizona Coral, Micrurus Euryxanthus, is found in Arizona and New Mexico. The Coral snake characteristically is a small thin snake with a small round black eye. The fangs are fixed, not hollow and the venom flows down grooves in the fangs. The snakes do not "strike" but hold and "chew" their victim. This allows the venom to flow over the wound into the fang marks. The snakes are are waxy, shiny in appearance, and are usually colored alternating red, yellow and black bands. The head of the Coral snake is black. A black or melanistic form and a white albino form have been described. The Coral snake lives under loose soil, leaves, debris, etc. They are a burrowing type snake and are usually uncovered by raking or working in the ground. They are shy and elusive, but when excited their movements become rapid and apparently purposeless. These

thrashing movements are designed to bring the snake's head close to the body for the bite[12].

Venom

Coral snake venom is almost purely paralytic in action. There is no tissue reaction and the pain is only that of the fangs. There is usually a delay of symptoms of several hours. This is a characteristic of the Coral and the Krait, and initially may lull the physician into a false sense of security.

Symptoms

Several hours after the bite, apprehension, giddiness, ptosis of the eyelids, euphoria, lethargy, nausea, salivation, vomiting and weakness occur. Convulsions may occur, along with a bulbar type paralysis, involving the cranial nerves, and respiratory paralysis. Peripheral paralysis follows, but the sensorium remains clear until death. All of these effects of the venom apparently are reversible and completely paralyzed patients have recovered.

If young children develop these signs unexpectedly while in the southern states, remember to check for fang marks. There have been instances where children either are not able to talk, or afraid to talk and these signs of neuromuscular collapse have been due to the Coral snake. Diagnosis in these instances was made by finding fang marks.

Treatment

All patients should be hospitalized.

1. Observation for symptoms of envenomation for at least 24 hours including respiration checks every 30 minutes.
2. Have a tracheostomy set and respirator and antivenin available.
3. Check urine for blood every hour as hematuria is a common finding.
4. Wash the bite area. Frequently there is venom deposited on the skin around the fang marks. Any attempt to cut and suck may re-envenomate the patient.
5. If signs of envenomation occur, start an I.V. with three to five vials of Coral Antivenin after skin testing. Do not give intramuscularly.
6. Tetanus Prophylaxis.
7. Do not use respiratory depressants, use sedatives with extreme caution.
8. Maintain ventilation and blood pressure at all times. The antivenin is not effective for the Arizona Coral Snake, but no fatalities have ever been reported from this snake.

Antivenin

Antivenin is the keystone of successful snake bite treatment. The pit viper antivenin is manufactured from hyperimmune horse serum. The venoms used for its manufacture are the tropical rattler (C.D.Terrificus), the fer-de-lance (Bothrops, Atrox), the Eastern Diamondback (C. Adamanteus) and the Western Diamondback (A. Atrox). It is effective against all North and South American pit vipers, also those of Korea, Japan and the Trimeresurus spp. of the Pacific Islands. Antivenin is available at most hospital emergency rooms and larger drug stores.

Coral antivenin is manufactured from horse serum using venom from M.F. Fulvius,(North Florida Coral). It is effective against all Coral bites except the Sonora Coral snake. This antivenin is available at the National Communicable Disease Center of the United States Public Health Service, Atlanta, Georgia (telephone-404-6333-3311). Many hospitals and poison control centers and State Health Departments of the southern states also stock the Coral antivenin.

Reactions to Antivenin

The immediate reaction (anaphylaxis) of antivenin is similar to that of horse serum anaphylaxis elsewhere. Treatment is simply shutting off the I.V. and administering adrenalin through the I.V. tubing. It is suggested that a syringe of adrenalin be kept loaded and available when administering the horse serum intravenously.

Serum sickness may occur in six to 24 days. Symptoms are fever, malaise, lymphadenopathy, arthralgia and urticaria. Neurological signs such as meningismus or peripheral neuritis may occur. The peripheral neuritis usually involves the shoulders and arms, (upper brachial plexus). Pain and muscle weakness are frequently present and permanent atrophy may develop. Accelerated reactions are the same as above but occur in a few minutes to two to five days. Cortisone is beneficial in these latter two conditions.

Local reactions are usually manifested by progressive erythema, edema and itching of the skin tested area. The Arthus phenomenon occurs at the site of repeated injections. There is local necrosis which may progress to gan-

(Continued on page 548)



ll, Dr. Cunningham! I was just telling Herbert should talk to you about my allergy. ist my nose starts to tickle and..."

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NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relax smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

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Splenectomy and Splenorenal Shunt For Hypersplenism and Bleeding Esophageal Varices†

E. Truman Mays. M.D.. and Sam D. Weakley. M.D.

Louisville, Kentucky

Various portal-systemic shunts have been devised to decompress the portal venous system and control hemorrhage from esophageal varices. A splenorenal shunt after splenectomy is specific in patients with splenomegaly, pancytopenia, portal hypertension and bleeding esophageal varices.

HEMORRHAGE from esophageal varices is one of the leading causes of death in patients with portal hypertension. Esophageal variceal bleeding is the most lethal form of gastrointestinal hemorrhage known. It is the most frustrating kind of bleeding from the gastrointestinal tract that physicians are called upon to manage.

In 1877 a young Russian Army surgeon, Nickolai Vladimerovich Eck[1], reported construction of a fistula between the portal vein and inferior vena cava in dogs. He had been stimulated by Lautenbach's[2] observation that ligation of the portal vein caused death. Eck wanted to prove that the portal vein could be ligated with impunity. His experiments were interrupted because he was called to active military duty, but he suggested that ascites in humans might be relieved by construction of such a fistula. A pathologist[3] urged surgeons in 1928 to try an Eck fistula for the relief of portal hypertension. This advice went unheeded for 10 to 15 years. Since then numerous variations of Eckian and other portal-systemic shunts have been devised by surgeons in efforts to manage the serious sequelae of portal hypertension.

It is generally agreed that decompression of the portal system by establishing a portal-systemic shunt is the most effective measure for controlling hemorrhage and preventing future bleeds from esophageal varices. Beyond this area of general agreement, there is considerable controversy about the type of portal-systemic shunt that most effectively decompresses the portal system. Volumes of data have accumulated advocating one particular fistula over another.

In this brief report we do not wish to propose any particular shunt as having greater efficacy than others. The purpose of this paper is to call attention to a small group within the larger group of patients with portal hypertension in whom splenectomy and a splenorenal venous shunt is indicated.

Case Reports

Case No. 1. A 42-year-old gravida IX, para VII, ab II, was admitted to the Methodist Hospital in May of 1969, with the complaint of vomiting large amounts of bright red blood. She had been in good health until the day of admission, and had gone to work as usual. While on the job she developed abdominal cramps and pain. The patient stated this was the first time she had ever vomited blood. Several years before she had a cesarean section, and following the section she developed severe hemorrhage which required her to be returned to the operating room three times.

On physical examination, a brachial blood pressure was 90/60mm Hg. and the pulse 120/min. The liver was four centimeters below the right costal margin, the spleen six centimeters below the left costal margin. There were no spider angiomata nor other stigmata of cirrhosis. After admission to the hospital the hemogram showed a pancytopenia

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Read before the annual meeting of the Kentucky Chapter of the American College of Surgeons, Lexington, Kentucky, March 13-14, 1970.

(Table 1). An esophagram demonstrated massive esophageal varices (Fig. 1a), and the bone marrow showed a hyperplastic red cell series with good stimulation and a marked shift to the left. The myeloid series and megakaryocytes were not remarkable. Liver function studies showed a Bromsulfalein retention of 11 per cent, SGOT 23 units, SGPT 15 units. The serum bilirubin was 0.8 mgms per cent and serum albumin 2.9 grams per cent.

During the next seven days she was given 10 units of whole blood and her hemoglobin rose to 14 grams per cent with a hematocrit of 40 per cent. There was no further bleeding from the esophageal varices. The white blood count remained low (1,100 cu. mm.) and the platelet count dropped to 48,000 per cu. mm.

Surgery was performed on May 23, 1969. A 1490 gram spleen was removed and a large two centimeter diameter splenic vein was dissected free from the pancreas and anastomosed with cardiovascular suture end-to-side with the renal vein, establishing a widely patent shunt. The pathology report on the spleen showed chronic congestive splenomegaly with septal cirrhosis and reactive hyperplasia of the lymph nodes. A liver biopsy showed post hepatitic cirrhosis. Postoperatively the leukopenia and thrombocytopenia were quickly corrected (Table 2). Because of the leukopenia we gave her gamma globulin and placed her in isolation the first 48 hours after surgery. Rheomacrodex (500 ml/24 hrs) was given intravenously post-shunting because of the increased platelet count. She was discharged home on the eighth post-operative day. An esophagram 10 months later (Fig. 1b) showed marked regression of the massive varices.

Case No. 2, a male, age 43, was admitted to the Baptist Hospital August 23, 1969, because of gastrointestinal bleeding. Since February, 1969, he had recurrent episodes of

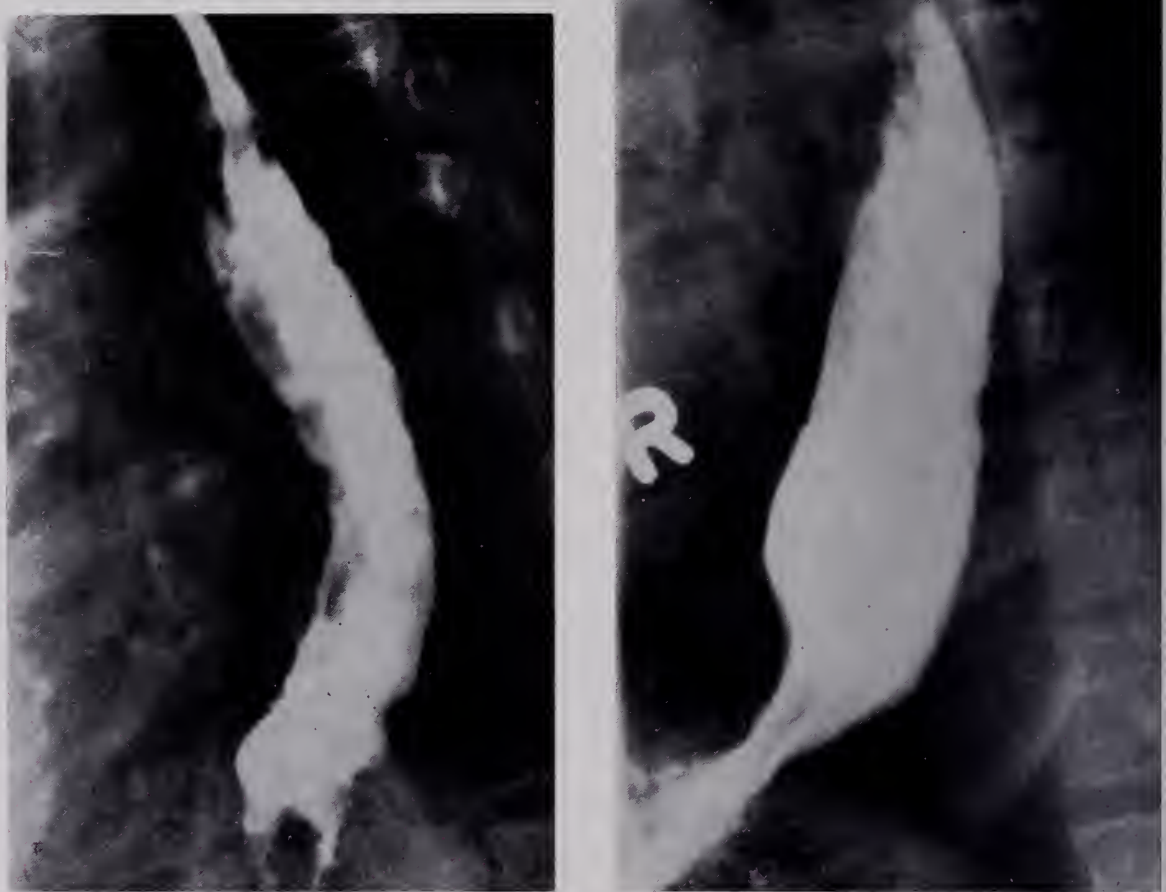


FIG. 1 (a) The esophagus is filled after a Barium meal and shows extensive large varices (b). Ten months after splenorenal shunt there is marked regression of the esophageal varices.



FIG 2. The massive esophageal varices demonstrated preoperatively in a 43-year-old man (a) disappear after a fistula between the splenic and left renal vein is constructed; (b) esophagram seven months after surgery.

dark tarry stools, and hematemesis. In May, 1969, he was admitted to the hospital for gastrointestinal bleeding, and had a vagotomy and pyloroplasty. At the time of surgery no duodenal ulcer could be demonstrated and the bleeding was unexplained. In July, 1969, he was referred to a hematologist because of a pancytopenia. At that time he was noted to have hepatomegaly, splenomegaly and spider angiomata. He is also a diabetic of three years duration and uses 25 units of Lente Insulin per day. Several brothers in his family have diabetes.

Table 1

W.B.C.	1,500/cu. mm.
R.B.C.	2,100,000/cu. mm.
Hematocrit	16 percent
Platelets	46,000/cu. mm.

Pancytopenia observed in a 42-year-old female with hepatosplenomegaly admitted because of acute gastrointestinal hemorrhage.

Physical Examination: A brachial blood pressure was 118/70 mm Hg., and pulse 75/min. The liver was palpable two centimeters below the right costal margin and the spleen four centimeters below the left costal margin. After admission to the hospital, an esophagram (Fig. 2a) showed massive esophageal varices and this was confirmed by esophagoscopy. Anemia, leukopenia and thrombocytopenia were present. During his hospital course his hemoglobin continued to drop to a low of 7.3 gms. per cent, with a hematocrit of 21 per cent. There were 60,000 platelets per cu. mm. and his white count continued to drop to a low level of 1,800 per cu. mm. Liver function studies showed a normal SGOT, LDH and bilirubin. The serum albumin was 4.19 gms. per cent; bromsulfalein retention 6 per cent and prothrombin time 13.9 seconds with the control being 12.3 seconds. He received eight units of blood in preparation for surgery.

On September 1st, the spleen was removed and the splenic vein was noted to be markedly dilated. The splenic vein was dissected free of the pancreas by ligation of tributaries, the left renal vein was isolated and the splenic vein anastomosed to the renal vein, end-to-side. Immediately after surgery his platelet count rose to 235,000 per cu. mm. and his white count to 15,900/cu. mm. The patient's postoperative course was complicated by a fever of 101 to 102° F for several days but then subsided and the remainder of his postoperative course was uneventful. Antibiotics were given throughout the recovery period. He was discharged home on September 9th, 1969. A postoperative esophagram seven months later showed the esophageal varices to have disappeared (Fig. 2b) The patient was doing extremely well at the seven month follow-up.

Table 2

	W.B.C.	PLATELETS
PRE-OP	1,500	46,000
POST-OP:		
24 hours	12,300	117,000
48 hours	19,500	136,000
6 days	10,300	949,000

The leukocyte and thrombocyte count per cu. mm. show rapid recovery after splenectomy.

Discussion

In 1898 Banti[4] reported a form of splenomegaly associated with anemia, leukopenia and thrombocytopenia. It has since been shown quite conclusively that the histologic picture in the spleen described by Banti was not specific but could be seen in a number of clinical situations of chronic congestion of the spleen. No clinical nor hematologic differences have been found between patients with congestive splenomegaly due to intra- or extrahepatic obstruction except in cases of far-advanced portal cirrhosis. After splenectomy the blood values return to normal. These observations support the view that Banti's Syndrome is the consequence of any of a variety of lesions causing portal venous hypertension.

Chauffard, in 1907, first used the term "hypersplenism," in referring to the concept that the spleen may in situations of pathologic exuberance produce leukopenia, thrombocytopenia and anemia.[5, 6] Today the term is widely used and has been qualified to primary and secondary hypersplenism; the former when the underlying disease is unknown and the latter when some well defined disorder can be identified. Secondary hypersplenism is usually associated with splenomegaly.

Both of our patients demonstrated hypersplenism and congestive splenomegaly. There was anemia, leukopenia and thrombocytopenia present in each. Their anemias were more striking because of blood loss from esophageal varices. Although one hesitates to take patients with thrombocytopenia to the operating room for major surgery, in this particular situation it is not usually a significant problem. Platelet counts rise rapidly following removal of the spleen and usually go well beyond the normal range as demonstrated by case one. We did not find it necessary to use platelet transfusions nor cortisone preoperatively to try to alleviate the thrombocytopenia as some have advocated. Clotting at surgery was normal and bleeding in the postoperative period was not a problem in either of these patients.

Because of the rather marked leukopenia in Case no. 1 we were concerned about hospital resistant infections in the early postoperative period. Antibiotics are ineffective in preventing bacterial invasion when the leukocytes are severely depressed. We placed the patient on strict gown, cap, mask and glove isolation and administered human gamma globulin .06 cc/lb of body weight intramuscular. There was no evidence of sepsis; her white blood count rapidly returned to normal, and isolation techniques were discontinued.

Linton[7] advocates the splenorenal shunt because in his experience the adverse nutritional effects on the liver and the incidence of encephalopathy are less than after portacaval shunts. A number of investigators are not willing to accept this and believe that there is no great advantage of the splenorenal shunt over other forms of portal-systemic shunting. Neither of the patients presented here showed any signs of hepatic encephalo-

(Continued on page 548)

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in the Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.



Liability Insurance

RILEY LASSITER*

The KMA Plans and Development Committee spent the entire day, February 5, 1970, discussing liability insurance. The Committee members felt that all Kentucky physicians might be interested in seeing a summary of the remarks presented by representatives of two companies who carry liability insurance in Kentucky.

Kentucky physicians have generally been able to secure professional liability insurance at rates well below the national average. Coverage at rate commensurate with the individual risk has been available for those physicians who have proved to have a higher than average risk. Still, the cycle of increased numbers of claims, increased cost of resolving claims and the consequently increased insurance premiums has begun to spin viciously in Kentucky as elsewhere. Publication of a United States Senate Subcommittee hearing on malpractice has focused additional attention on the problem, as have national, state and local conferences, articles in professional journals and massive publicity (mostly unfriendly to physicians) in the public media. The increasing concern is evidenced by a growing number of physicians being actively interested and asking how this situation can be effectively countered.

Recommendations of solutions have appeared from many sources. Careful, objective analysis of available information on such of these proposals as pre-trial screening panels and society-sponsored, group malpractice insurance programs indicate not only a failure to resolve the problem, but a propensity towards aggravating the problem. Physicians in Kentucky are fortunate that no such artificially created conditions have been imposed as in California, Florida, New York, New Jersey, New Mexico and Arizona where the situation has reached crisis proportions. Your societies are to be commended for a no-nonsense approach to the problem which is implicit in the rejection of schemes of questionable merit.

New or revised laws to protect doctors have been suggested by some parties. The re-establishment by legislation of toppled defensive barriers would seem appropriate for consideration **insofar as the public's interests have been similarly breached.** Extreme caution should be exercised when considering the legislative route so that the profession's good will with the public and legislators is not frittered away on peripheral issues or issues which may rebound to the profession's detriment. For example, a prominent plaintiff's attorney recently referred to Good Samaritan legislation as "nonsense" and an example of doctors panicking over nonexistent fears. His reaction, which may well be representative of a large body of opinion, will serve to make the passage of other, more meaningful, legislation far more difficult.

The profession rightly desires to retain the privilege of "policing" itself in the face of growing public discontent over the apparent miniscule restrictions being placed upon physicians as compared to the rapidly increasing numbers of negligence claims against doctors. However, the profession is now caught in a dilemma, and the other, unpublicized horn is

*Riley Lassiter, representative, The Medical Protective Company.

the liability assumed by a doctor when he sits in judgement of his peers. Legislatively created immunity from prosecution for members of committees reviewing the performances of their peers might ultimately serve to improve the level of care received by the public as well as remove the insurance burden of questionable risk practitioners from the remainder of the profession.

Positive measures can be taken by the profession, individually and in concert. Special continuing attention must be paid to preventive procedures in each doctor's practice. At the heart of **every** claim, no matter what the subject matter, no matter what its merit, at the center is a patient dissatisfied with the treatment accorded him by a doctor. It is here, with this causative factor in mind, that firm and lasting improvement must be founded. Among the other potentially advantageous activities would be involvement in the selection of judges, cooperation with insurers, a willingness to testify in court when requested and participation in seminars on malpractice prevention which are kept within the confines of the state and local medical societies. Knowledge of potentially dangerous procedures or situations within a doctor's practice can be a positive aid in eliminating the danger.

The situation confronting the profession is an extremely complex one, and there are no simple answers which are effective. The effective solutions require hard and continuous efforts by the profession, their insurance carriers and their defense attorneys. My company will continue to support constructive measures designed to enhance the defense of physicians.

The Rise in Malpractice Claims

The Cause, Effect and Cure

Jo. M. Van Zandt*

IT was not too long ago when it was considered a shameful stigma for a physician to be accused of malpractice, but today it is a fairly common occurrence. What are the causes for the change? The following are the principal ones:

1) Due to modern medical technology, physicians (in the eyes of juries) are expected sometimes to do the impossible.

2) Actions by judges and state legislatures are circumventing the medical profession's reticence to testify against one another. Several states have passed laws expanding the permissive use of medical textbooks as evidence. This places opinions of eminent medical authors at the disposal of a plaintiff's attorney.

3) In recent cases, judges have been more willing to waive the time-honored "locality rule" which requires the physician to meet only the standards of medical care in his community. The Massachusetts Supreme Court reversed an appeal last year saying in its decision: ". . . The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases . . ." Professional standards must be uniform, in the eyes of the court, thus depriving the defense of some time-honored arguments.

4) The abandoment by some courts of the requirement that plaintiffs prove negligence when the injury resulted from an error. The theory of **Res ipsa Loquitur,** the thing speaks for itself, is proving highly significant. This shifts to the doctor being sued the burden of proving he was blameless, and making it possible for a plaintiff to win a case without producing any witnesses. Previously the burden was on the patient to prove the doctor was at fault.

5) Inflation! Courts are more generous in the amount of judgements, and costs of defense are soaring.

What effect does this have on professional liability insurance? You know the answer — soaring premiums! It must be conceded that insurance companies are in business to make a profit. This is fair, and they are required by Kentucky Statutes to file with the Commissioner of Insurance their experience data before

*Jo. M. Van Zandt, representative, Aetna Insurance Company

any change of rates is considered. The actuarial art of insurance rate-making is a complicated science, particularly in the professional liability field. The filing of claims by plaintiffs is usually made a considerable time after the incident, or the discovery of the incident, giving rise to a claim. For this reason, the actuaries work with old data, and must prognosticate on the rates necessary to produce enough money to cover claim payments and expenses, plus a five per cent profit factor, allowed by the Department.

In recent years, major companies writing this coverage in Kentucky (there are only three principal ones) have suffered loss ratios of 100 per cent, and their data have been substantiated by the Kentucky Insurance Department. The Department therefore has granted the requested increases that you are now required to pay.

You might ask — are insurance companies paying unjustified claims? The answer to this is simply NO. Policies sold in Kentucky contain a clause stating that the company will not settle or compromise any claim or suit without the written consent of the insured. Therefore, if payment is to be made, the insured physician must agree in writing. Rest assured that no insurance company is anxious to pay more than a claim is worth.

The cure? There is no "cure-all prescription," but there are certain important things a physician can do to reduce his chances of being sued for malpractice. They are:

1) Keep good records! Make no entries on charts that you could not substantiate in court.

2) Avoid needless criticism of professional services rendered by others.

3) Avoid procedures outside of the realm of capabilities and training.

4) Fully inform the patient (and the family if appropriate) of the expected results, and the fee to be charged for the professional services.

5) Keep abreast of medico-legal developments. Interpretations of the laws change, and new precedents are being set frequently.

If the above rules are followed, the number of claims will surely be greatly reduced resulting in lower insurance costs.

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EDITORIALS

A Reply To The Critic

There probably has never been a time in our country's history when there has been as much interest in health affairs as the present. It is said by people in and out of government—and by spokesmen of the news media—that we are in a "health crisis". The physician, as the most conspicious member of the health team, has suddenly found himself as the target of much criticism. The criticism seems to come from all directions and the physician finds himself being held responsible for all sorts of grevious errors of both omission and commission.

One of the favorite implications of the "doctor critic" is that it is the doctors who are primarily responsible for the rapid increase in medical costs. There are some interesting figures available in response to this implication. Of the total expenditures for Medicare for the year 1969—22.6 per cent represented physicians' fees. Of the total expenditure for Medicaid in 1969—11.4 per cent went to physicians.

The Consumer Price Index (Department of Labor) has some interesting figures having to do with price increases between 1964 and 1969. In this interval of time the physician's fee for an office visit went up 37.8 per cent while auto insurance went up 38.1 per cent; laundry bills 42 per cent; repairing a furnace, 44 per cent; repainting a room, 50 per cent; a hospital room (semi-private) went up 86 per cent.

It is said by the critic that doctors could control medical costs if they really were interested and wanted to. It is a fact that it is hospital costs that make up the major component of medical costs. The physician has very little control over hospital costs. Seventy per cent of hospital costs are the result of wages of employees of the hospital. The remaining 30 per cent is the cost of materials and supplies. Here again, the main factor in determining the cost of the material or supply is the wage of the worker producing it.

The principal reason for the very large percentage increase in hospital cost from 1964 to 1969 is the application of the Minimum Wage Law to hospital employees which went into effect in 1967. Prior to 1967, hospital employees were behind the rest of the labor market insofar as wages are concerned. Since 1967 there has been a rapid catching up of hospital employee wages to the mean of the labor market—and this has been the major factor in the rapid rise of hospital costs. It is evident that the physician has no control over what has to be paid in hospital employee salaries—or in the costs of food and other materials which the hospital is required to purchase.

In spite of the vigorous doctor criticism it is evident that the physician's fee is not a major factor in the present cost of medical care.

WALTER S. COE, M.D.



PROTEIN CONTENT / 7 oz. Serving*

Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
Beef	8.0	Hot Dog Bean	8.4
Chicken Broth	5.5	Pepper Pot	6.1
Chicken 'N Dumplings	5.8	Split Pea with Ham	10.2
Chili Beef	6.2	Vegetable Beef	5.0
Green Pea	6.9	Vegetable with Beef (Frozen)	5.4

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* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 365, Camden, New Jersey 08101.

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(when her husband's at fault)

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Only a systemically active medication like Flagyl is capable of reaching the hidden reservoirs of infection in the genitourinary tracts of both men and women.

Only Flagyl has been able to achieve rates of cure consistently above 90 per cent and often up to 100 per cent in trichomonal infections in both men and women.

Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . 500 mg.

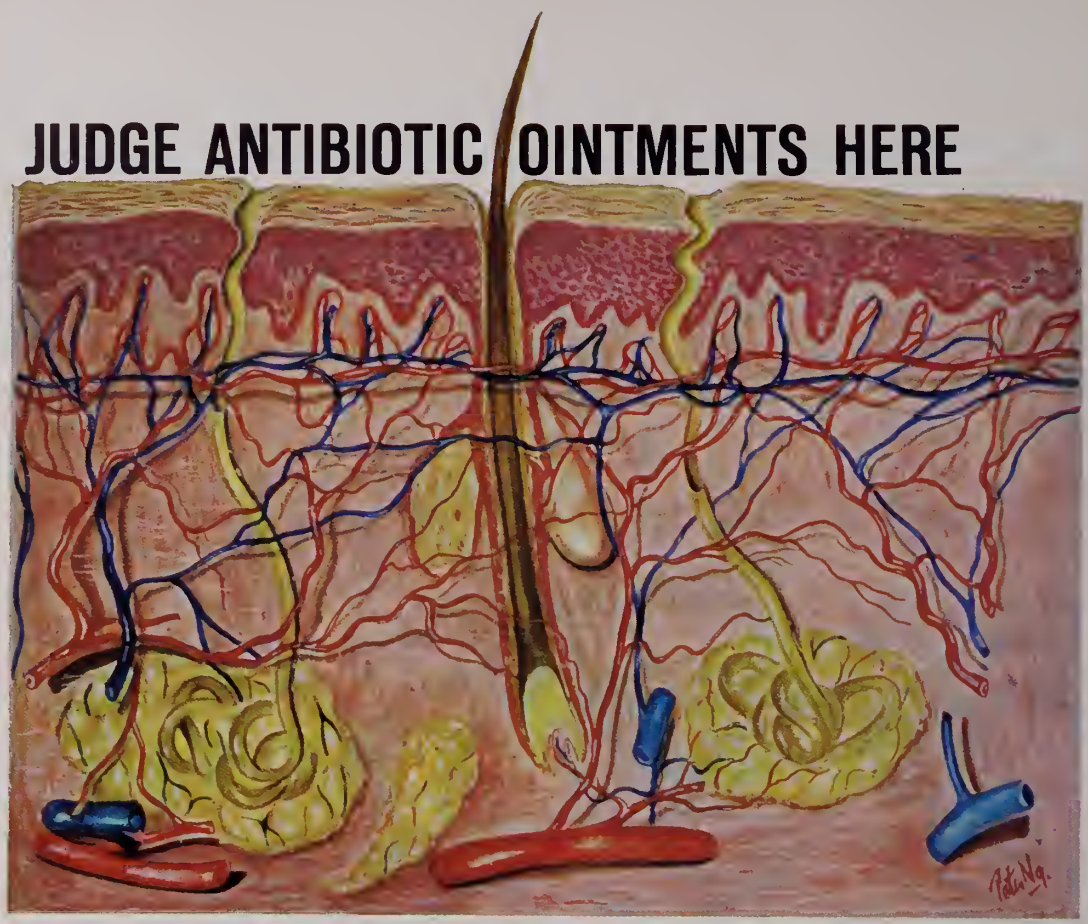
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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

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City .....State ..... Zip .....

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Arrival Date .....

Hour* .....AM PM

Departure Date .....

Kentucky Medical Association — Annual Meeting — September 22-24, 1970

***Rooms will not be held after 6 p.m. unless requested.**

PRE-REGISTRATION FORM

1970 KMA Annual Meeting — Convention Center

September 22-24, 1970 — Louisville

(Please Print or Type)

NAME .....

ADDRESS .....
(Number & Street) (City) (County) (State)

☐ KMA Member ☐ Intern or Resident

☐ Non-Member Physician ☐ Medical Student

FIELD OF PRACTICE .....

KENTUCKY MEDICAL ASSOCIATION
1970 ANNUAL MEETING
LOUISVILLE
SEPTEMBER 22-24, 1970

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Kentucky Medical Association
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Louisville, Kentucky 40205

A Link in the Chain

auxiliary

Dear Doctor:

Your wife is cordially invited to attend the 48th Annual Convention of the WOMAN'S AUXILIARY to the KENTUCKY MEDICAL ASSOCIATION. It will be held in conjunction with the ANNUAL MEETING of the KENTUCKY MEDICAL ASSOCIATION. The Scientific Sessions and Registration will be held in the Convention Center and the Auxiliary activities will be held in the Kentucky Hotel, September 21-24, 1970.

Whether your wife is a member of WAKMA or not she will be most welcome to attend any of the activities listed below. Will you please take this page home to her as OUR INVITATION, we are hoping to meet her.

Sincerely yours,
Mrs. Hoyt D. Gardner, President
Woman's Auxiliary to KMA

MONDAY, SEPTEMBER 21, 1970

2:30-4:30 p.m.
Get Acquainted Tea
President's Suite

6:00 p.m.
Cocktail Party sponsored by
University of Louisville Alumni
Flag Room

7:00 p.m.
KEMPAC Dinner and Seminar
Flag Room

TUESDAY, SEPTEMBER 22, 1970

8:30 a.m.
Preconvention Board Meeting and
Breakfast

8:30-10:30 a.m.
Continental Breakfast
Mezzanine

10:00 a.m.
48th CONVENTION OPENING SESSION
Mirror Room

10:30 a.m.-5:00 p.m.
Silent Auction and Gift Boutique
Mezzanine

12:15 p.m.
ZODIAC LUNCHEON
Terrace Room
"STARDUST"—A Jewelry Fashion Show
"MEDICINE'S METEORITE—YOU THE AUXILIARY"
Guest Speaker—Rex Kenyon, M.D.,
Oklahoma City, Okla.

5:30-7:00 p.m.
Cocktail Party Honoring Presidents-Elect
John C. Quertermous, M.D., KMA
Mrs. C. E. Hornaday, W A K M A
Mirror Room

WEDNESDAY, SEPTEMBER 23, 1970

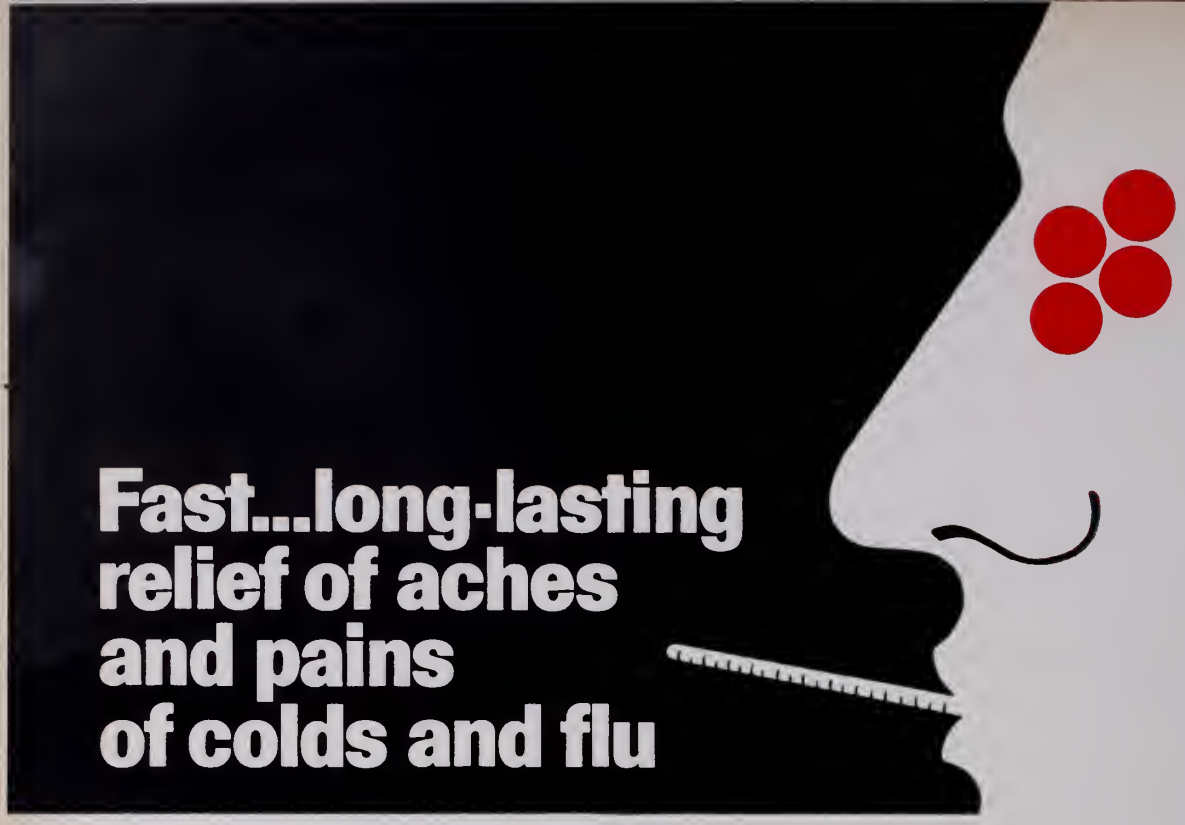
8:30-10:30 a.m.
Continental Breakfast
Mezzanine

9:00-11:45 a.m.
W A K M A BUSINESS SESSION

10:00 a.m.-2:00 p.m.
Silent Auction and Gift Boutique
Mezzanine

12:00 noon
KMA President's Luncheon
Flag Room
Guest Speaker—Ralph Lee Smith, Author,
"At Your Own Risk", the book that
exposed Chiropractic.

All friends and guests are cordially invited to attend all sessions, whether or not you are a member of W A K M A. Please register in the lobby. We will be HAPPY to see you.



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Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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Available: Bottles of 12, 36 and 60 tablets.

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Annual Meeting Section

KMA OFFICERS 1969 — 1970



WALTER L. CAWOOD, M.D.
PRESIDENT



David A. Hull, M.D.
Vice President

PRESIDENT-ELECT
John C. Quertermous, M.D.
Murray

Doctor Quertermous will be installed as president of the Kentucky Medical Association Wednesday evening, September 23, during the 1970 Annual Meeting in Louisville. Very active in the work of the Association, he has served as a delegate to the AMA from 1963-1969, a former chairman of the Committee on Legislative Activities for National Affairs, and a former chairman of the KEMPAC Board of Directors. He has also been a member of the KMA Board of Trustees since 1963.

A native of Livingston County, Doctor Quertermous graduated from Murray State College in 1938 and received his M.D. degree from the University of Louisville School of Medicine in 1942. After completing his internship at Good Samaritan Hospital in Cincinnati, he served three and a half years in the U.S. Army, serving in the Pacific Theatre. He was separated in 1946 as a major.

After completing a residency in internal medicine at Louisville General Hospital, Doctor Quertermous began his private practice in Murray in 1950. He is a past president of the Calloway County Medical Society and served on the Governor's Citizens Committee on the Problems of the Aging in 1960 and 1961.

Doctor Quertermous is recognized as an outstanding member of his profession for his work in medicine and for his active participation in local civic affairs. For these and other reasons, Doctor Quertermous is an excellent choice as president-elect of the Kentucky Medical Association.

VICE PRESIDENT
David A. Hull, M.D., Lexington

Active in the affairs of local and state medicine, Doctor Hull has practiced general surgery in Lexington since 1954. A 1947 graduate of the University of Tennessee Medical School, he is also an associate clinical professor of surgery at the University of Kentucky Medical Center. He is past president of the Fayette County Medical Society and currently the secretary-treasurer of the Kentucky Chapter, American College of Surgeons. A fellow of the American College of Surgeons, Doctor Hull has served on the KMA Committee on Legislative Activities and is a member of the Southern Surgical Congress and the International Cardiovascular Society.

Secretary and Treasurer

SECRETARY
S. Randolph Scheen, M.D., Louisville

Doctor Scheen, serving his third year as secretary of KMA, is an instructor in medicine at the University of Louisville School of Medicine and chief of dermatology at St. Joseph's Infirmary. A 1953 graduate of the University of Louisville School of Medicine, Doctor Scheen is a member of the American Academy of Dermatology, the Noah Worcester Dermatologic Society and the Alumni Association of the Mayo Foundation. He is also a member of KMA's Judicial Council.



TREASURER
Keith P. Smith, M.D., Corbin

Treasurer of the Association since 1963, Doctor Smith has been active in KMA affairs, serving as a former vice president and chairman of the Board of Trustees. A general surgeon, Doctor Smith graduated from the University of Louisville School of Medicine in 1936. He is a past president and vice president of the Kentucky Academy of General Practice. He has practiced for a number of years in Corbin where he was the first chief of staff of the Corbin Municipal Hospital.



Journal Editors

EDITOR
Walter S. Coe, M.D., Louisville

Now serving as president of the Jefferson County Medical Society, Doctor Coe is in his fourth year as editor of **The Journal.** He has also served as associated editor and book review editor. An associate clinical professor of medicine at the University of Louisville School of Medicine, Doctor Coe graduated from that institution in 1943. He is a past president of the Kentucky, Louisville and Jefferson County Heart Associations and the Kentucky Society of Internal Medicine.



ASSOCIATE EDITOR
Sam A. Overstreet, M.D., Louisville

President of KMA during its Centennial in 1950-51, Doctor Overstreet served as editor of **The Journal** for eight years. A 1923 graduate of the University of Louisville School of Medicine, Doctor Overstreet is a past governor of the Kentucky Chapter, American College of Physicians, a past president of the Jefferson County Medical Society, and a former speaker of the KMA House of Delegates. He is a member of the State Board of Health and the Southern Medical Association.



ASSISTANT EDITOR
Walter I. Hume, Jr., M.D., Louisville

A 1949 graduate of Harvard Medical School, Doctor Hume is an assistant clinical professor of surgery at the University of Louisville School of Medicine. He is the past president of the Jefferson County Medical Society and has been active in committee work both in the Society and in KMA. He now serves as chairman of the KMA Committee on Medical Education. Doctor Hume is a member of the Southern Surgical Association, as well as the International Society of Surgery.



AMA Delegate
J. Thomas Giannini, M.D., Louisville

Doctor Giannini has served as a delegate to the AMA since 1963 and was previously an alternate delegate. A 1938 graduate of the University of Louisville School of Medicine, he is a fellow of the American College of Surgeons and the American Society of Plastic and Reconstructive Surgeons. He is a member of the Kentucky and Louisville Surgical Societies and is a former chairman of the KMA Scientific Exhibits Committee.



AMA Delegates

Charles C. Rutledge, M.D., Hazard

Doctor Rutledge, who graduated from the University of Louisville School of Medicine in 1946, has served as a delegate to the AMA since 1965. Formerly an alternate delegate to KMA, he is also past president of the Pike and Perry County medical societies, a past KMA Councilor and a former district chairman for KEMPAC. A fellow of the American College of Surgeons, Doctor Rutledge is a member of the Southern Medical Association.



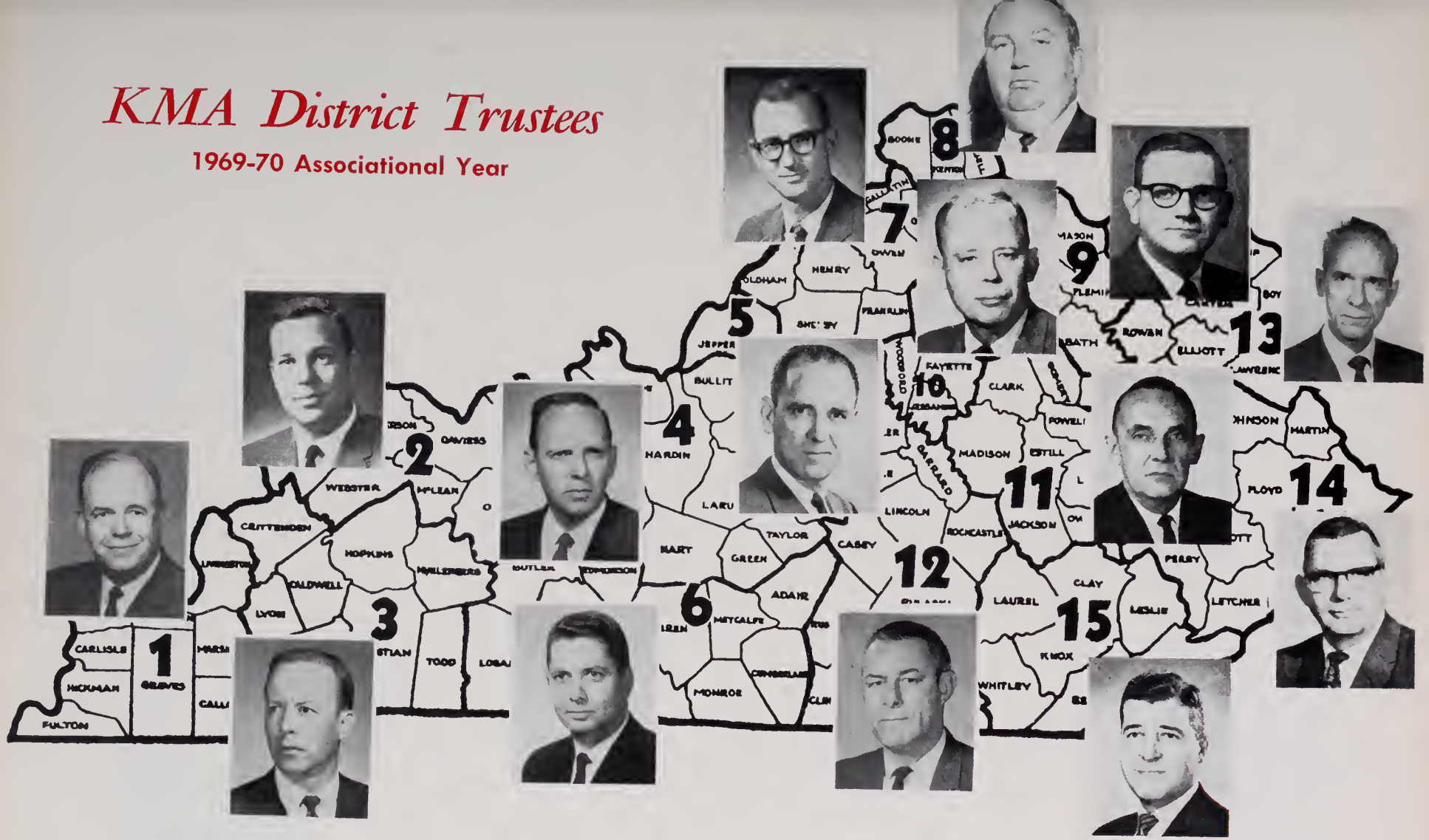
George F. Brockman, III, M.D., Greenville

An internist who graduated from the University of Louisville School of Medicine in 1935, Doctor Brockman was elected a delegate to the AMA at the 1969 Annual Meeting. Active in the affairs of the Association, Doctor Brockman served as KMA president in 1968-69 and has been speaker and vice-speaker of the KMA House of Delegates. He recently served as chairman, Kentucky Tuberculosis Study Committee, Comprehensive Health Planning Committee.



KMA District Trustees

1969-70 Associational Year



1. C. C. LOWRY, Murray
2. WILLIAM W. HALL*†, Owensboro
3. THORNTON E. BRYAN, JR.*, Cadiz
4. W. BRUCE HAMILTON, Shepherdsville
5. JOHN S. LLEWELLYN*, Louisville
6. PAUL J. PARKS, Bowling Green
7. DONALD CHATHAM, Shelbyville
8. LEE C. HESS*, Florence
9. J. CAMPBELL CANTRILL, Georgetown
10. ANDREW M. MOORE, Lexington
11. DOUGLAS H. JENKINS, Richmond
12. ROBERT N. McLEOD, JR., Somerset
13. PAUL E. HOLBROOK, Ashland
14. BALLARD W. CASSADY, Pikeville
15. E. C. SEELEY, London

†*Chairman of the Board*
**Member of the Executive Committee*

New Trustees

Paul J. Parks, M.D., Bowling Green

A 1948 graduate of the University of Louisville School of Medicine, Doctor Parks has practiced internal medicine in Bowling Green since 1958. He is a member of the Kentucky and American Society of Internal Medicine, as well as the Southern Medical Association. He has been a delegate to KMA from Warren County since 1963 and serves on the KMA Special Committee on Medicine and Religion.

John S. Llewellyn, M.D., Louisville

An associate professor of clinical medicine at the University of Louisville School of Medicine, Doctor Llewellyn received his M.D. degree from Loyola University School of Medicine in 1940. A fellow of the American College of Physicians, Doctor Llewellyn is a member of the American, Kentucky and Louisville Heart Association, the American Society of Internal Medicine, and the Kentucky Diabetes Association.

Election of Trustees and Alternate Trustees

The **House of Delegates** will elect five district trustees and five alternate trustees at its second session, Wednesday, September 23. Nominations will be made by the delegates from the electing districts at a meeting following the first session of the House on Monday, September 21. At the close of the first scientific session on Tuesday, September 22, the committee will report its nominees. Further nominations may be made from the floor at the final meeting of the House of Delegates, Wednesday evening, September 23. All nominations are considered and acted upon by the delegates at this final session.

Districts electing trustees for three-year terms are: **SECOND DISTRICT** (incumbent William W. Hall, M.D., Owensboro); **SEVENTH DISTRICT** (incumbent Donald Chatham, M.D., Shelbyville); **NINTH DISTRICT** (incumbent J. Campbell Cantrill, M.D., Georgetown); **TENTH DISTRICT** (incumbent Andrew M. Moore, M.D., Lexington); **THIRTEENTH DISTRICT** (incumbent Paul E. Holbrook, M.D., Ashland). All are eligible for re-election with the exception of Doctor Chatham who has served two full terms.

Districts electing alternate trustees are the same as those electing trustees. Incumbents are Kenneth M. Eblen, M.D., Henderson (2nd); Thomas P. Leonard, M.D., Frankfort, (7th); James L. Ferrell, M.D., Paris (9th); Irving Kanner, M.D., Lexington (10th); and Arthur B. Richards, M.D., Louisa (13th). All alternate trustees are eligible for re-election.

Officers of the House of Delegates

SPEAKER
Richard F. Greathouse, M.D., Louisville



Elected as vice-speaker of KMA House of Delegates in 1965, Doctor Greathouse is now serving his second term as speaker. A 1951 graduate of the University of Louisville School of Medicine, Doctor Greathouse is an assistant clinical professor of pediatrics. He is a past secretary-treasurer of KEMPAC and is a past president of the Louisville Pediatric Society. Doctor Greathouse also has served as vice chairman of the Kentucky Chapter, American Academy of Pediatrics.

VICE-SPEAKER
Carl C. Cooper, M.D., Bedford



A 1952 graduate of the University of Louisville School of Medicine, Doctor Cooper has been active in the affairs of KMA. He is a former KMA vice president and alternate delegate to the AMA. He is also a past vice president of the Kentucky Academy of General Practice and a member of the American Academy of General Practice. This is currently his second term as vice-speaker of the House.

KMA Delegates

ADAIR
James C. Salato, Columbia

ALLEN
Earl P. Oliver, Scottsville

ANDERSON
Boyd Caudill, Lawrenceburg

BALLARD

BARREN
William H. Bryant, Glasgow

BATH
Robin A. Byron, Owingsville

BELL
Kenneth W. Smith, Middlesboro
Charles B. Stacy, Pineville

BOONE
Glenn F. Baird, Florence

BOURBON
Richard Wever, Paris

BOYD
C. Gordon Gussler, Ashland
Garner E. Robinson, Ashland
Clyde C. Sparks, Ashland

BOYLE
John M. Baird, Danville

BRACKEN
J. M. Stevenson, Brooksville

BREATHITT
F. C. Lewis, Jackson

BRECKINRIDGE
James G. Sills, Hardinsburg

BULLITT
Patrick Murphy, Lebanon Junction

BUTLER

CALLOWAY
Hugh Houston, Murray

CAMPBELL-KENTON
Carl J. Brueggemann, Covington
Thomas L. Heavern, Jr., Highland Heights
Donald Janney, Covington
Louis J. Nutini, Erlanger
W. Vinson Pierce, Covington
R. C. Smith, Newport

CARLISLE
J. T. O'Neill, Arlington

CARROLL
Edgar S. Weaver, Carrollton

CARTER
H. E. Shufflebarger, Grayson

CASEY
Lewis E. Wesley, Liberty

CLARK

CLAY
W. E. Becknell, Manchester

CLINTON
Earnest A. Barnes, Albany

CRITTENDEN
R. M. Brandon, Marion

CUMBERLAND
James W. Morris, Burkesville

DAVIESS
Coy Ball, Owensboro
J. S. Oldham, Owensboro
William E. Pearson, Owensboro

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ELLIOTT
John F. Greene, Sandy Hook

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Richard B. McElvein, Lexington
Carl H. Scott, Lexington
Ben C. Stigall, Lexington

FLEMING
Samuel W. Gehring, Flemingsburg

FLOYD
George Archer, Prestonsburg

FRANKLIN
B. B. Baughman, Frankfort
Sandford L. Weiler, Frankfort

FULTON
R. W. Bushart, Fulton

GALLATIN
John D. Fielding, Jr., Warsaw

GARRARD
Paul J. Sides, Lancaster

GRANT

GRAVES
C. Douglas Le Neave, Mayfield

GRAYSON
Charles L. Bland, Leitchfield

GREEN
Harry B. Huntsman, Greensburg

GREENUP
John O. Jones, Flatwoods

HANCOCK
B. P. Smith, Hawesville

HARDIN
Fred C. Rainey, Elizabethtown
Robert E. Robbins, Elizabethtown

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Henry C. Evans, Harlan

HARRISON
Don R. Stephens, Cynthiana

HART
George B. Boeckmann, Horse Cave

HENDERSON
Kenneth Eblen, Henderson
Charles Kissinger, Henderson

HENRY

HICKMAN
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LINCOLN
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Donald L. Boucher, Paducah
W. Burton Haley, Paducah
Walter Johnson, Paducah

McCREARY
H. A. Perry, Whitley City

McLEAN
Everett S. Coleman, Sacramento

MADISON
Glynn Reynolds, Richmond
Dwight L. Blackburn, Berea

MAGOFFIN

MARION

MARSHALL
Keith Ellis, Benton

MARTIN
Raymond D. Wells, Inez

MASON
William Savage, Maysville

MEADE

MENIFEE

MERCER
John S. Baughman, III, Harrodsburg

METCALFE
L. P. Emberton, Edmonton

MONROE
J. E. Carter, Tompkinsville

MONTGOMERY
R. J. Salisbury, Mt. Sterling

MORGAN
Morris Peyton, West Liberty

NELSON
Kenneth L. Stinnette, Bardstown

NICHOLAS
W. R. Kingsolver, Carlisle

OHIO
R. E. Norsworthy, Hartford

OLDHAM

OWEN
Maurice Bowling, Owenton

OWSLEY
Arnold Taulbee, Beattyville

PENDLETON
Robert L. McKenney, Falmouth

PENNYRILE
Caldwell: Billy G. Jackson, Princeton
Christian: James B. Cox, Hopkinsville
W. Faxon Payne, Hopkinsville
Muhlenberg: J. Keith Linville, Central City
Todd: Jesse C. Woodall, Trenton
Trigg: Wm. N. Richardson, Cadiz

PERRY
Donald Martin, Ary

PIKE
H. E. Altman, Pikeville
Paul Odum, Elkhorn City

POWELL
Charles G. Noss, Stanton

PULASKI
John P. Hill, Jr., Somerset
Stephen B. Kelley, Somerset

ROBERTSON

ROCKCASTLE
George H. Griffith, Mt. Vernon

ROWAN

RUSSELL
James E. Monin, Jamestown

SCOTT
R. Kendall Brown, Georgetown

SHELBY
Ronald Waldridge, Shelbyville

SIMPSON
Douglas R. Alvey, Franklin

SPENCER
Wm. K. Skaggs, Taylorsville

TAYLOR
Roy G. Wilson, Campbellsville

TRIMBLE
Carl Cooper, Jr., Bedford

UNION
Wallas N. Bell, Sturgis

WARREN
Paul J. Parks, Bowling Green
J. O. Willoughby, Bowling Green

WASHINGTON

WAYNE
Claude L. McHargue, Monticello

WEBSTER
Paul M. Taylor, Providence

WHITLEY
Roemer D. Pitman, Williamsburg

WOLFE
Sam E. Cecil, Campton

WOODFORD
George C. Reed, Versailles

MAKE YOUR RESERVATIONS NOW

It is most important this year that hotel reservations be made as soon as possible for the KMA Annual Meeting, September 22-24. Hotels and motels in downtown Louisville have excellent accommodations and are available within easy access of Convention Center if plans are made today to secure these reservations. Use the reservation form on page 519.

Save Time At Annual Mtg., Pre-Register TODAY

You can avoid standing in a long line at the Annual Meeting registration desk by completing the postcard on page 519 and sending it to the KMA Headquarters Office as soon as possible.

Your badge will be ready at the window marked "Pre-Registration" on your arrival at the meeting. You are urged to take advantage of this opportunity and send the postcard today.

Delegates to KMA and members of the Board of Trustees do not need to pre-register as this is automatically done for them.

Reference Committee Activity

Speaker Richard F. Greathouse, M.D., Louisville, will assign **all officers' and committees' reports and resolutions** to one of six reference committees **at the first meeting of the KMA House of Delegates at 9 a.m. Monday, September 21.** Reference committee chairman will meet for briefing sessions at 12:30 p.m. Monday in Room 317, Kentucky Hotel. **Reference committees will meet on the mezzanine floor of the Kentucky Hotel at 2 p.m. Monday, September 21 and any KMA member wishing to testify on any resolution or report is urged to be present.** These open sessions will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the committees will go into executive sessions to study the reports, review the testimony and write their reports to the House.

The committees' recommendations will be presented **at the final session of the House, Wednesday night, September 23,** in the Terrace Room, Kentucky Hotel. Listed below are the reference committees appointed by Doctor Greathouse to serve during the 1970 session.

1970 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1
Parlor B

Harold L. Bushey, M.D., Barbourville, Chairman
Glenn F. Baird, M.D., Florence
Winston L. Burke, M.D., Lexington
Frank M. Gaines, Jr., M.D., Louisville
Walter R. Johnson, M.D., Paducah

REFERENCE COMMITTEE NO. 2
Room 203

Faull S. Trover, M.D., Madisonville, Chairman
Peter P. Bosomworth, M.D., Lexington
Harry B. Huntsman, II, M.D., Greensburg
Edwin P. Solomon, M.D., Louisville
James O. Willoughby, M.D., Bowling Green

REFERENCE COMMITTEE NO. 3
Room 204

Cecil L. Grumbles, M.D., Louisville, Chairman
Carl J. Brueggemann, M.D., Covington
Jerry D. Fraim, M.D., Paintsville
John P. Hill, Jr., M.D., Somerset
John S. Oldham, M.D., Owensboro

REFERENCE COMMITTEE NO. 4
Parlor C

Thomas L. Heavern, M.D., Highland Heights, Chairman
Branham B. Baughman, M.D., Frankfort
W. Neville Caudill, M.D., Louisville
Hugh L. Houston, M.D., Murray
Leslie W. Blakey, M.D., Lexington

REFERENCE COMMITTEE NO. 5
Parlor D

Glenn W. Bryant, M.D., Louisville, Chairman
Thomson R. Bryant, M.D., Lexington
Billy G. Jackson, M.D., Lexington
Stephen B. Kelley, M.D., Somerset
Raymond D. Wells, M.D., Inez

REFERENCE COMMITTEE NO. 6
Parlor A

John F. Berry, Jr., M.D., Lexington, Chairman
George P. Archer, M.D., Prestonsburg
James B. Cox, M.D., Hopkinsville
Edward N. Maxwell, M.D., Louisville
W. Vinson Pierce, M.D., Covington

OFFICIAL CALL
KMA Annual Meeting

To the officers and members of the component county medical societies of the Kentucky Medical Association.

Meeting Place

The Annual Meeting of the KMA will convene on Tuesday, Wednesday and Thursday, September 22, 23 and 24, at Convention Center, Louisville. The first general session will be called to order at 8:50 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 9 a.m., Monday, September 21. The second regular business session will begin at 7 p.m., Wednesday, September 23. A subscription dinner will be served to the delegates preceding the session at 6 p.m. Both sessions will be held in the Terrace Room of the Kentucky Hotel.

Registration

The registration desk will open at the Terrace Room of the Kentucky Hotel at 8 a.m., Monday, September 21, and at 5:30 p.m., Wednesday, September 23. It will be open in the technical exhibit hall of Convention Center from 8 a.m. to 5 p.m. Tuesday, Wednesday and Thursday, September 22-24.

1970-71 KMA Officers Elected By House At Annual Meeting

The House of Delegates will elect the KMA officers for the 1970-71 Associational year at the close of its final session Wednesday evening, September 23. Officers to be selected by the House are:

President-Elect	**(Central)**	**One Year**
Vice President	**(Western)**	**One Year**
***AMA Delegate**		**Two Years**
(J. Thomas Giannini, M. D., Louisville,		**incumbent)**
***AMA Alternate Delegate**		**Two Years**
(Charles G. Bryant, M. D., Louisville,		**incumbent)**

**Eligible for re-election*

Nominating Committee To Meet After First Session of House

An open meeting of the KMA Nominating Committee will be held following the close of the first session of the House of Delegates Monday, September 21, at the alcove of the Terrace Room of the Kentucky Hotel.

Any KMA member has the privilege of conferring with the Committee during this meeting. Final recommendations of the Committee will be reported at the end of the first scientific session Tuesday morning, September 22.

Nominations may be made from the floor at the second meeting of the House of Delegates, Wednesday evening, September 23. The House will vote on the nominees at the close of this session.

Members of the Nominating Committee, chaired by W. E. Becknell, M. D., Manchester, are Clyde Brassfield, M. D., Elizabethtown; Thomson R. Bryant, Jr., M. D., Lexington; W. Faxon Payne, M. D., Hopkinsville, and W. Fielding Rubel, M. D., Louisville.

Number To Call Is 584-2201 In Case of Emergency

In case of an emergency or for routine messages, you may be reached at the Message Center set up during the Annual Meeting. The number of this Center is (502) 584-2201. Staffed at all times during the Meeting, the Message Center will be located in the center of the Technical Exhibit Hall at the Convention Center.

Only emergency calls will be posted on the blackboard in the entrance lobby of Convention Center and in the Scientific Assembly Hall. All other messages will be kept on file at the Message Center until you call for them. You are asked to check there frequently for your messages.

Paging of individual physicians is not possible due to the arrangement of facilities for the meeting.

If you wish to locate other physicians attending the meeting, you may do so by calling the Message Center at 584-2201 and asking that your message be delivered.

The phone number at the Kentucky Hotel is 587-1181. You should have your calls directed to the Terrace Room if you are attending the meetings of the House of Delegates on September 21 (beginning at 9 a.m.) or September 23 (beginning at 6:00 p.m.). When you receive a call your name will be posted on the blackboard at the front of the room.

You are urged to make use of the Message Center which is located conveniently and efficiently for the transfer of messages. Be sure to leave these phone numbers at your home, office and hospital.

REGISTRATION INFORMATION

A Registration Booth will be located in the north end of the Convention Center (in the Technical Exhibit Hall) throughout the Annual Meeting. The booth will open at 8 a.m. Tuesday, Wednesday and Thursday, September 22-24.

Please wear your badge at all times while attending the meeting.

Annual Meeting Special Features



The Kentucky Hotel
KMA Annual Meeting Headquarters

SCIENTIFIC SESSIONS featuring prominent guest speakers from throughout the country and Kentucky physicians are scheduled on September 22, 23 and 24 at the Convention Center. The scientific presentations, which are both timely and informative for today's physicians, will deal with such topics as "Emergencies," "Cardio-Pulmonary Resuscitation," "Industrial Medicine" and "Tuberculosis." A Crackerbarrel Session will be held again this year at the Wednesday afternoon session.

SIXTEEN SPECIALTY GROUPS will hold their meetings on the afternoons of September 22 and 24. No general session is scheduled for either afternoon. All KMA members are invited to attend any of these meetings in which they are interested.

THE HOUSE OF DELEGATES, KMA's top policy-making body, will meet Monday, September 21 at 9 a.m. and Wednesday, September 23 at 7 p.m. in the Terrace Room of the Kentucky Hotel. Officers for 1970-71 will be elected at the final session.

THE PRESIDENT'S LUNCHEON will feature Ralph Lee Smith, New York, N. Y., author of "At Your Own Risk." Mr. Smith's address is titled "I Get The Treatment" and is based on a chapter taken from his book exposing chiropractic. KMA's three top awards will also be presented at the luncheon which will be held at 11:50 a.m., Wednesday, September 23 in the Flag Room of the Kentucky Hotel.

SEVENTY-FIVE TECHNICAL EXHIBITS will display a variety of medical products and services in Convention Center during the Annual Meeting. Members will have the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty group session.

ALUMNI REUNIONS will be held for the five-year classes of the University of Louisville School of Medicine.

THE WOMAN'S AUXILIARY TO KMA will hold its 48th Annual Convention September 22-24 at the Kentucky Hotel. Special entertainment and business sessions have been planned.

New KMA Members To Be Offered 11th Orientation Course, Sept. 21

Approximately 100 new KMA members will have an opportunity to participate in the Eleventh KMA Orientation Program which will be held in the Mirror Room of the Kentucky Hotel on Monday, September 21, just prior to the opening session of the 1970 KMA Annual Meeting.

The members of the KMA Orientation Committee have spent much time preparing an outstanding program. The program has been redesigned this year to provide more information in a more condensed manner and will better equip new members to meet their responsibilities as citizens and as physicians. The Orientation session will begin with registration at 8 a.m. The program will start promptly at 8:30 a.m. and will adjourn by noon.

Letters of invitation have been sent to all KMA members who have joined the Association during the past two years and have not attended an Orientation Program. Any KMA member is welcome to attend the course whether or not he receives an invitation. Following is the program to be presented on September 21.

Eleventh KMA Orientation Program

C. Wyatt Norvell, M.D., New Castle
Moderator

8:00 a.m. **Registration**
8:25 a.m. **Call to Order**
8:30 a.m. **Welcome and Introduction**
Walter L. Cawood, M.D., Ashland
KMA President

Structure—Function—Policies in Organized Medicine

8:40 a.m. **"Your KMA"**
Henry B. Asman, M.D., Louisville,
Narrator, KMA Past President

9:05 a.m. **"County Medical Society and Community Relations"**
C. Wyatt Norvell, M.D., New Castle
Co-Chairman, KMA Orientation Committee

9:20 a.m. **"American Medical Association"**
Robert C. Long, M.D., Louisville

9:35 a.m. **"Health Insurance" (Blue Cross-Blue Shield)**
G. Douglas Sutherland, Louisville
Director, Professional Relations
Kentucky Physicians' Mutual, Inc.
Blue Cross Hospital Plans, Inc.

9:50 a.m. **"Health Insurance" (Commercial)**
Francis J. Batridge, Louisville
Metropolitan Life Insurance Company

10:05 a.m. **COFFEE BREAK**

10:20 a.m. **"Peer Review of Fees"**
Marvin A. Bowers, Jr., M.D., Louisville
Chairman, KMA Claims and Utilization Review Committee

10:35 a.m. **"Cults"**
David B. Stevens, M.D., Lexington
Chairman, KMA Cults Committee

10:50 a.m. **"Medico-Legal Aspects"**
E. Gaines Davis, Jr., Frankfort
KMA Legal Counsel

11:05 a.m. **"The Physician's Role in Legislation and Politics"**
Hoyt D. Gardner, M.D., Louisville
Chairman for National Affairs
KMA Committee on Legislative Activities

11:20 a.m. **Question and Answer Period**

KEMPAC Seminar To Feature Two U. S. Senators, Sept. 21

Two U.S. Senators, Edward J. Gurney (R), Florida and Jennings Randolph (D), West Virginia will be the guest speakers at the annual KEMPAC Seminar Monday evening, September 21 in the Flag Room of the Kentucky Hotel. A reception at 6 p.m. will be followed by a dinner at 7 p.m. and the seminar, according to C. Kenneth Peters, M.D., Louisville, chairman of the KEMPAC Board.

Senator Gurney and Randolph have been asked to discuss "Government Involvement in Medicine" and "Physician Involvement in Government."

Prior to Senator Gurney's election to the Senate in 1968, he served in the U.S. House of Representatives in the 88th, 89th and 90th Congresses. He now serves on the Committee on Government Operations, Public Works Committee, Special Committee on the Aging and the Republican Campaign Committee.

Senator Randolph, elected to the U.S. House of Representatives in 1932, served 14 consecutive years in that capacity. In 1958 he was elected to the U.S. Senate to complete the term ending January, 1961. He was then re-elected in 1960 and 1966. Senator Randolph serves on the Committee on Public Works as its chairman, Committee on Labor and Public Welfare, Committee on Post Office and Civil Service, Select Committee on Small Businesses, Special Committee on Aging and Select Committee on Equal Educational Opportunity.

All physicians and their wives are urged by the KEMPAC Board of Directors to make plans to attend this exciting and informative affair.

Glaucoma Screening Plans Set

Plans for a glaucoma screening booth during the KMA Annual Meeting, September 22-24, have been made by the Kentucky Society for the Prevention of Blindness, according to David McClure, M. D., project chairman.

Set up in the Louisville Convention Center, the glaucoma screening booth will be open to everyone attending the Annual Session. Any general practitioner interested in observing "tonometry" should drop by the booth where an ophthalmologist will be on duty at all times.

Take This Issue Home to Your Wife

Walter L. Cawood, M.D., KMA President, urges you to take this issue home for your wife to read. Many activities planned during the Annual Meeting will be of interest to her. A summary of the program of the Woman's Auxiliary Annual Convention is on page 521.

1970 Annual Meeting Program Summary

The Kentucky Medical Association

September 20, 21, 22, 23 and 24

Louisville

SUNDAY, SEPTEMBER 20

12:30 p.m. Luncheon Meeting, KMA Board of Trustees ..... Parlor A, Kentucky Hotel

MONDAY, SEPTEMBER 21

8:30 a.m. Orientation Program, New KMA Members ..... Mirror Room, Kentucky Hotel
9:00 a.m. First Meeting, KMA House of Delegates ..... Terrace Room, Kentucky Hotel
12:30 p.m. Luncheon for Reference Committee Chairmen ..... Room 317, Kentucky Hotel
2:00 p.m. Reference Committee Meetings ..... Parlors A, B, C, D—Rooms 203 & 204, Kentucky Hotel
6:00 p.m. KEMPAC Reception, Banquet and Seminar ..... Flag Room, Kentucky Hotel

TUESDAY, SEPTEMBER 22

8:50 a.m. Opening Ceremonies ..... Scientific Assembly Hall, Convention Center
9:00 a.m. Registration ..... Technical Exhibit Hall, Convention Center
9:00 a.m. First Scientific Session ..... Scientific Assembly Hall, Convention Center
12:00 noon Board of Trustees Luncheon & Meeting ..... Parlor A, Kentucky Hotel
2:00 p.m. Specialty Group Sessions, Convention Center (Eight Specialty Group Sessions will be held simultaneously at this time. Any KMA member may attend any of these meetings. There will be no General Session at this time. See pages 536-538 in program!.

WEDNESDAY, SEPTEMBER 23

9:00 a.m. Second Scientific Session ..... Scientific Assembly Hall, Convention Center
11:50 a.m. President's Luncheon ..... Flag Room, Kentucky Hotel
2:00 p.m. Third Scientific Session ..... Scientific Assembly Hall, Convention Center
5:00 p.m. Meeting, Board of Trustees ..... Parlor B—Dinner at 6:00, Parlor A, Kentucky Hotel
6:00 p.m. Subscription Dinner and Meeting, House of Delegates ..... Terrace Room, Kentucky Hotel

THURSDAY, SEPTEMBER 24

9:00 a.m. Fourth Scientific Session ..... Scientific Assembly Hall, Convention Center
12:00 noon Board of Trustees Luncheon and Afternoon Meetings ..... Parlor A, Kentucky Hotel
2:00 p.m. Specialty Group Sessions, Convention Center (Eight Specialty Group Sessions will be held simultaneously at this time. Any KMA member may attend any of these meetings. There will be no General Session. See pages 540-542 in program).

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting Scientific and Technical Exhibits.

(Full Scientific Program Starts on page 536)

The Kentucky Medical Association

SCIENTIFIC PROGRAM

J. A. Ouchterlony Memorial Meeting

Convention Center, Louisville

TUESDAY, SEPTEMBER 22
MORNING SESSION

General Session

Walter L. Cawood, M.D., Ashland, KMA President, Presiding

8:50 **Opening Ceremonies**

Theme: "EMERGENCIES"

9:00 **"Emergency Treatment of Aspiration Pneumonia"**
Bradley E. Smith, M.D., Nashville, Tenn.

9:20 **"Evaluation and Management of Drug Reactions"**
William Lester, M.D., Denver, Colo.

9:40 **"Obstetrical Hemmorrhage"**
George C. Lewis, Jr., M.D., Philadelphia, Pa.

10:00 **Intermission to Visit Exhibits**

10:30 **"Croup"**
Margaret H. D. Smith, M.D., New Orleans, La.

10:50 **"Psychiatric Emergencies"**
Shervert Frazier, M.D., New York, N.Y.

11:10 **"Urologic Emergencies"**
Donald J. Jaffar, M.D., Southfield, Mich.

11:30 **"Vascular Injuries Associated With Fracture"**
J. Leonard Goldner, M.D., Durham, N.C.

TUESDAY, SEPTEMBER 22
AFTERNOON SESSION

Eight Specialty Group Meetings

(The scientific programs of eight specialty groups, beginning at 2 p.m., will feature prominent guest speakers from throughout the country. All KMA members are invited to attend the specialty group meetings of their choice. There will be no general scientific session at this time.)

Kentucky Society of Anesthesiologists
Room 101, Convention Center

2:00 **"Pulmonary Toxicity of Therapeutic Oxygen"**
Bradley E. Smith, M.D., Nashville, Tenn.

2:30 **"Volts-Amps and Patients"**
Lloyd F. Redick, M.D., Lexington

3:00 **Intermission to Visit Exhibits**

3:30 **Business Meeting**

BRADLEY E. SMITH, M.D.

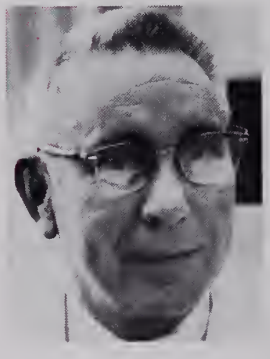
Nashville, Tennessee



Professor and chairman, deportment of onesthesialagy, Vonderbilt University School of Medicine. M.D., 1957, University of Oklahama. Fellaw, American College of Anesthesialogists. Chairman, Obstetric Anesthesio Committee, American Society of Anesthesialogists. Member, Respirotary Diseose of Newborn Committee, American College of Chest Physicians. Assaciate Fellaw, American College of Obstetricions ond Gynecologists.

THOMAS WILLIAM LESTER, M.D.

Denver, Colorado



Professar of medicine, University of Calarada. M.D., 1941, University of Chicaga of Chest Physicians, American Acodemy of Micrabiology. Member, Committee an Therapy, American Tharacic Society. Member, Central Society for Clinicol Research, American Assaciatian for Advancement of Science.

MARGARET H. D. SMITH, M.D.

New Orleans, Louisiana



Professor of pediatrics ond epidemialagy, Tulane Medical School and Tulane School of Public Health. M.D., 1939, Johns Hopkins School of Medicine. Member, Baord of Scientific Counselors, NIH Divisian of Biologics Standards. Pediatric consultant, Bristal Labaratories. Member, Americon Acodemy of Pediatrics, Americon Assaciation of Immunalagists, American Society of Micrabialagy, Infectious Disease Society of America, Society for Experimentol Bialagy ond Medicine.

Kentucky Chapter, American College of Chest Physicians
Room 104, Convention Center

Fireside Conferences

2:00 **"Hiatal Hernia and Peptic Esophagitis"**
John S. Harter, M.D., Louisville
Paul M. Walstad, M.D., Harlan
Samuel H. Cheng, M.D., Louisville

"Coronary Artery Disease—Surgical or Medical Treatment"
David S. Nightingale, M.D., Louisville
William G. Malette, M.D., Lexington
Ralph Shebatai, M.D., Lexington
Robert N. Class, M.D., Lexington

"E.K.G. Interpretations"
Albert G. Goldin, M.D., Louisville
Franklin G. Hoffman, M.D., Louisville

"Radiology—X-Ray Interpretation and Lung Scanning"
Edward N. Maxwell, M.D., Louisville
Paul VanLith, M.D., Lexington
Leonidas Mostowycz, M.D., Lexington
Arthur Lieber, M.D., Lexington

"Pulmonary Disease—Tuberculosis, Fungi, Emphysema"
Nathan Levene, M.D., Louisville
Michael L. Furcolow, M.D., Lexington
Ernest Chick, M.D., Lexington
Paul A. Pichardo, M.D., Glasgow

"Pulmonary Functions—Inhalation Therapy"
Grover B. Sanders, M.D., Louisville
Ronald W. Dunbar, M.D., Lexington
Jerome S. King, M.D., Lexington

3:00 **Intermission to Visit Exhibits**

3:30 **Resume of Meeting of Fireside Conferences**

4:15 **Business Meeting**

Kentucky Obstetrical and Gynecologic Society
Room 205, Convention Center

2:00 **"The Relationship of Carcinoma in situ to Invasive Cancer"**
Richard Penny, Lexington
J. W. Roddick, Jr., M.D., Lexington

2:15 **"Experience with Carcinoma of the Cervix at U of K Medical Center"**
Thomas McQuire, M.D., Lexington
J. W. Roddick, Jr., M.D., Lexington

2:30 **"Management of Recurrent Carcinoma of the Cervix"**
George C. Lewis, M.D., Philadelphia, Pa.

3:00 **Intermission to Visit Exhibits**

3:30 **"Report of the Maternal Mortality Study Committee of the Kentucky Medical Association"**
John Petry, M.D., Fern Creek
John W. Greene, Jr., M.D., Lexington

Kentucky Orthopaedic Society
Room 207, Convention Center

2:00 **"The Use of Osteotomy in Management of Arthrosis of the Hip"**
J. Leonard Goldner, M.D., Durham, N.C.

2:30 **"Total Hip Replacement"**
Bryant A. Bloss, M.D., Louisville

3:00 **Intermission to Visit Exhibits**

SHERVERT H. FRAZIER, JR., M.D.
New York, New York



Professor of clinical psychiatry, Columbia University College of Physicians and Surgeons. Attending psychiatrist, Presbyterian Hospital and St. Luke's Hospital, New York. M.D., 1943, University of Illinois. M.S., 1957, University of Minnesota. Secretary, Section on Nervous and Mental Diseases, AMA. Secretary, American Board of Psychiatry and Neurology. Member, American College of Psychiatrists, Association for Psychoanalytic Medicine. Member of several editorial boards.

DONALD J. JAFFAR, M.D.
Southfield, Michigan



Clinical professor of urology, Wayne State University School of Medicine. M.D., 1928, University of Michigan. Past president, American Urological Association, Inc. Fellow, American College of Surgeons. Member, American Association of Clinical Urologist. Author or co-author of over 75 articles relating to medicine and urology.

J. LEONARD GOLDNER, M.D.
Durham, North Carolina

Professor and chairman, division of orthopaedic surgery, Duke University Medical Center. M.D., 1943, University of Nebraska. President, Southern Medical Association. Past president, American Society for Surgery of the Hand. Member, American Academy of Orthopaedic Surgeons, American Orthopaedic Association, National Institute of Health, American Academy of Cerebral Palsy. Former editorial positions with The Journal of Bone and Joint Surgery and Bulletin, American Academy of Orthopaedic Surgeons.



DONALD M. THOMAS, M.D.
Louisville, Kentucky



Assistant professor of anesthesiology, University of Louisville School of Medicine. M.D., 1955, University of Pennsylvania. Surgeon, Louisville Division of Fire. Member, International Narcotic Enforcement Officers Association, American Society of Anesthesiologists, New York Academy of Sciences.

Kentucky Chapter, American Academy of Pediatrics
Assembly Hall, Convention Center

2:00 "Shock in (Acute) Bacterial Infections"
Margaret H. D. Smith, M.D., New Orleans, La.

2:30 "Emergencies in the Neonatal Period"
Robert Beargie, M.D., Lexington
Billy Andrews, M.D., Louisville

3:00 Intermission to Visit Exhibits

3:30 "Management of Acute Bacterial Meningitis"
Margaret H. D. Smith, M.D., New Orleans, La.

4:00 "Pediatric Surgical Emergencies"
Robert P. Belin, M.D., Lexington

Kentucky Psychiatric Association
Room 204, Convention Center

2:00 "Psychiatric Treatment of Chronic Headache Patients"
Shervert Frazier, M.D., New York, N.Y.

2:30 "Psychiatry 1960—1970—1980"
Panel

3:00 Intermission to Visit Exhibits

3:30 "Psychiatry 1960—1970—1980" (cont'd)
Panel

4:00 Business Meeting

Kentucky Chapter, American College of Radiology
Room 208, Convention Center

2:00 "An Aggressive Approach to Roentgenological Diagnosis of Suspected Obstruction of the Small Intestine"
Sidney W. Nelson, M.D., Columbus, Ohio

2:30 "Interesting Case Presentations"
Orson Smith, M.D., Louisville

3:00 Intermission to Visit Exhibits

Kentucky Urological Association
Room 203, Convention Center

2:00 "Recurrent Urinary Tract Infections in Female Infants and Young Girls"
Donald J. Jaffar, M.D., Southfield, Mich.

2:30 "Discussion of Some of the Problem Areas With Which the A.U.A. is Concerned"
Donald J. Jaffar, M.D., Southfield, Mich.

3:00 Intermission to Visit Exhibits

3:30 Pyelogram Clinic

4:00 Business Meeting

WEDNESDAY, SEPTEMBER 23
MORNING SESSION

General Session

David A. Hull, M.D., Lexington, KMA Vice President, Presiding

Theme: "CARDIO-PULMONARY RESUSCITATION"

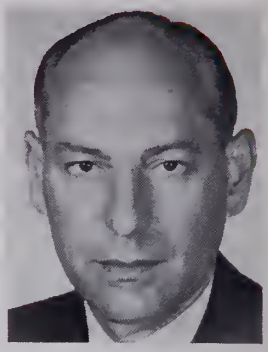
9:00 "The Nurse in Emergency Cardio-Pulmonary Resuscitation"
(Film)

9:20 "Ventilation and Circulatory Support"
Donald M. Thomas, M.D., Louisville

9:40 "Useful Drugs and Cardio-Pulmonary Resuscitation"
Borys Surawicz, M.D., Lexington

10:00 "Electrical Equipment"
Leonard Leight, M.D., Louisville

BORYS SURAWICZ, M.D.
Lexington, Kentucky



Professor of medicine and director, cardiovascular division, University of Kentucky College of Medicine. M.D., 1939, Stefan Batory University College of Medicine, Poland. Recent guest professor of physiology, University of Bern, Switzerlond. Fellow, American College of Physicians, American College of Cardiology, Council on Clinicol Cardiology. Member, American Heart Association, American Physiological Society, Association of University Cordiologists.

LEONARD LEIGHT, M.D.
Louisville, Kentucky



Clinicol ossociate professor of medicine, University of Louisville School of Medicine. M.D., 1945, Washington University School of Medicine, St. Louis. Co-chief, Cordiology Loboratory, Jewish Hospital, Louisville. Certified by the American Board of Internal Medicine.

GEORGE C. LEWIS, JR., M.D.
Philadelphia, Pennsylvania

Professor and chairman, department of obstetrics and gynecology, Hahnemann Medicol School. M.D., 1944, University of Pennsylvania School of Medicine. Fellow, American College of Obstetricians ond Gynecologists, American Gynecologicol Society. Past president, Society of Gynecologic Oncologists. Member, editorial board, Journal of the American College of Obstetricians and Gynecologists; Advisory Committee, Center Control Division, U.S.P.H.S.

No Photo Available

LAWRENCE E. MELTZER, M.D.
Philadlephia, Pennsylvania



Director, Coronary Core Unit, Section of Clinicol Investigation, Research Institute, Presbyterian, University of Pennsylvanio Medicol Center. M.D., 1952, University of Louisville School of Medicine. Associote Physician (Cardiology), University of Pennsylvonia.

10:20 Intermission to Visit Exhibits

10:50 "The Current Status and Future Direction of Intensive Coronary Care"
Lawrence E. Meltzer, M.D., Philadelphia, Pa.

11:10 "Artificial Organs and Human Transplantation"
C. Walton Lillehei, M.D., New York, N.Y.

11:30 Scientific Exhibit Award Presentation

PRESIDENT'S LUNCHEON

Flag Room, Kentucky Hotel
11:50 a.m.

Walter L. Cawood, M.D., Louisville
KMA President, Presiding

Invocation

Recognition
Walter L. Cawood, M.D.

Awards Presentation
Richard F. Grise, M.D., Bowling Green
Chairman, KMA Awards Committee

"I Get The Treatment"
Ralph Lee Smith, Author, *At Your Own Risk*

WEDNESDAY, SEPTEMBER 23
AFTERNOON SESSION

General Session

William W. Hall, M.D., Owensboro,
Chairman, Board of Trustees, Presiding

2:15 "The Future for the Coronary Disease Patient—Medicine or Surgery?"
C. Walton Lillehei, M.D., New York, N.Y.

2:35 "Principles of Treating Cardiogenic Shock"
Lawrence E. Meltzer, M.D., Philadelphia, Pa.

2:55 "Common Lesions of Oral Soft Tissues"
Robert R. Finch, D.D.S., Louisville

3:15 Intermission to Visit Exhibits

3:45 CRACKERBARREL SESSION

"The Value of Bronchography in the Differential Diagnosis of Bronchopulmonary Diseases"
Sidney W. Nelson, M.D., Columbus, Ohio

"Proficiency Testing in the Physician's Office Laboratories"
Raymond F. Hain, M.D., Oklahoma City, Okla.

"Severe Abdominal Trauma"
Robert N. McClelland, M.D., Dallas, Texas

"Current Status of the Therapy of Diabetes Mellitus"
David M. Kipnis, M.D., St. Louis, Mo.

"Management of Cardiac Arrhythmias"
Leonard Leight, M.D., Louisville

"Practical Experience in Cardio-Pulmonary Resuscitation Using an Electronic Simulator"
Donald M. Thomas, M.D., Louisville

"Rheumatic Fever"
Jacqueline Noonan, M.D., Lexington

"Peripheral Vascular Surgery"
Mohammad Atik, M.D., Louisville

"Problems in Gastric and Duodenal Ulcer"
Fred T. Moore, M.D., Louisville

"New Concepts in the Management of the Amputee"
James W. Harkess, M.D., Louisville

"Management of Neonatal Jaundice"
Jerry W. Seligman, M.D., Louisville

C. WALTON LILLEHEI, M.D.
New York, New York



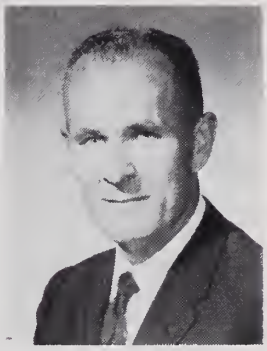
Lewis Atterbury Stinson professor of surgery and chairman, department of surgery, The New York Hospital-Cornell Medical Center. M.D., 1942, University of Minnesota. Recipient of numerous awards, including Susan and Theodore Cummings Humanitarian Award for "inspired teaching of cardiology" in the Philippines, Taiwan, Colombia, Chile, India and Pakistan. Recipient, The Gold Plate Award as 1968 Captain of Achievement, American Academy of Achievement. Fellow, American College of Surgeons, American College of Cardiology and American College of Angiology.

ROBERT R. FINCH, D.D.S.
Louisville, Kentucky



Associate professor and chairman, department of oral pathology, University of Louisville School of Dentistry. D.D.S., 1959, Ohio State University. M. Sc., 1968, Ohio State University. Fellow, American Academy of Oral Pathology. Member, American Association of Cancer Education, American Association of Dental Schools.

SIDNEY W. NELSON, M.D.
Columbus, Ohio



Professor and chairman, department of radiology, Ohio State University. M.D., 1945, Northwestern University. Past president, Association of University Radiologists, Society of Chairmen of Academic Radiology Departments. Member, American College of Radiology. Trustee, American Board of Radiology. Executive Council member, American Roentgen Ray Society.

RAYMOND F. HAIN, M.D.
Oklahoma City, Oklahoma



Clinical professor of pathology, University of Oklahoma School of Medicine. M.D., 1945, Jefferson Medical College. Member, American Society of Clinical Pathologists, American Academy of Neurology, American Association of Neuropathologists, College of American Pathologists. Author or co-author of numerous scientific articles.

"Office Gynecology"
Harold W. Baker, M.D., Louisville

"Malabsorption"
Samuel H. Cheng, M.D., Louisville

"Office Psychiatry"
William K. Keller, M.D., Louisville

"Selective Arteriography"
Chalmer Spencer Wheeler, M.D., Louisville

"Mental Retardation and Learning Problems"
Bernard Weisskopf, M.D., Louisville

"Management of Hypertension"
Angelo Ciliberti, M.D., Louisville

"Office Urology"
Lonnie W. Howerton, Jr., M.D., Louisville

"Chronic Renal Failure and Transplants"
Sidney G. Marcum, M.D., Louisville

"Common Office Dermatological Problems"
Maurice T. Fliegelman, M.D., Louisville

"Tetanus Immunization"
William T. Rumage, Jr., M.D., Louisville

THURSDAY, SEPTEMBER 24
MORNING SESSION

General Session

Thornton E. Bryan, M.D., Cadiz,
Vice Chairman, Board of Trustees, Presiding

Theme: "INDUSTRIAL MEDICINE"

9:00 "Diabetic Ophthalmopathy"
David E. Shoch, M.D., Chicago, Ill.

9:20 "Cutaneous Reactions to Some Environmental Intoxicants"
Donald J. Birmingham, M.D., Detroit, Mich.

9:40 "Alcoholism"
Marvin A. Block, M.D., Buffalo, N.Y.

10:00 Intermission to Visit Exhibits

Theme: "TUBERCULOSIS"

10:30 "Chemotherapy of Tuberculosis"
Vernon N. Houk, M.D., Atlanta, Ga.

10:50 PANEL DISCUSSION: "Problems in TB Therapy"
George F. Brockman, III, M.D., Greenville, Moderator
Thomas S. Moulding, Jr., M.D., Denver, Colo.
Vernon N. Houk, M.D., Atlanta, Ga.
Richard B. McElvein, M.D., Lexington

Specialty Group Meeting
Kentucky EEN&T Society
Room 205, Convention Center

9:00 "A Clinical Conference of Otolaryngological Problems: With Audience Participation"
John P. Frazer, M.D., Rochester, N.Y.

10:00 Intermission to Visit Exhibits

10:30 "Maxillectomy"
George I. Uhde, M.D., Louisville

11:00 "Salvaging Tympanoplasty Failures"
Theodore N. Steffen, M.D., Louisville

THURSDAY, SEPTEMBER 24, 1970
AFTERNOON SESSION

Eight Specialty Group Meetings

(Eight specialty groups will meet at 2 p.m. with outstanding speakers appearing on their programs. All KMA members are invited to these meetings. No general session will be held.)

ROBERT N. McCLELLAND, M.D.

Dallas, Texas



Associate professor of surgery, University of Texas Medical School. M.D., 1954, University of Texas Medical Branch, Galveston. Member, American College of Surgeons, Western Surgical Association, Society for Surgery of Alimentary Tract, Southwestern Surgical Congress. Author or co-author of numerous scientific articles.

DAVID M. KIPNIS, M.D.

St. Louis, Missouri

No Photo Available

Director, Clinical Research Center and professor of medicine, Washington University School of Medicine. M.D., 1951, University of Maryland School of Medicine. Member, editorial boards of several publications. Member, Advisory Board, Center for Population Research, National Institutes of Health; Scientific Advisory Board, U.S. Air Force. Recipient, Ernst Oppenheimer Award from the Endocrine Society, 1967.

DAVID E. SHOCH, M.D.

Chicago, Illinois



Professor and chairman, department of ophthalmology, Northwestern University Medical School. M.D., 1945, Northwestern University. Chief, department of ophthalmology, Passavant Memorial Hospital and Veterans Administration Research Hospital Trustee, Association of University Professors in Ophthalmology. Member, American Board of Ophthalmology, Association for Research in Ophthalmology, American Academy of Ophthalmology and Otolaryngology.

DONALD J. BIRMINGHAM, M.D.

Detroit, Michigan



Associate professor of medicine, Wayne State University. Chief of dermatology service, Detroit General Hospital. M.D., 1940, St. Louis University School of Medicine. Recipient, Surgeon General's Meritorious Award Medal, 1964. Fellow, American Academy of Dermatology and Syphilology, American College of Physicians. Member, American Conference of Governmental Industrial Hygienists, American Dermatological Association.

Kentucky EEN&T Society
Room 205, Convention Center

2:00 "Management of Retinal Vascular Occlusions"
David Shoch, M.D., Chicago, Ill.

3:00 Intermission to Visit Exhibits

3:30 "Uveitis in Kentucky"
Robert J. Kaiser, M.D., Louisville

3:15 "Blindness in Kentucky Children"
William C. Edwards, M.D., Louisville

4:10 "Electrodiagnostic Techniques in Ophthalmology"
Theodore Lawwill, M.D., Louisville

Kentucky Dermatological Society
General Hospital

2:00 Clinical Case Presentations
William Gillespie, M.D., Louisville, Moderator

3:00 Intermission to Visit Exhibits

3:30 General Discussion of Cases Presented
Donald J. Birmingham, M.D., Detroit, Mich.

Kentucky Chapter,
American Academy of General Practice
Assembly Hall, Convention Center

2:00 "Aldosteronism in Hypertensive Disease"
Jerome W. Conn, M.D., Ann Arbor, Mich.

3:00 Intermission to Visit Exhibits

3:30 PANEL DISCUSSION: "Hypertension in General"
Charles Smith, M.D., Louisville, Moderator
Jerome W. Conn, M.D., Ann Arbor, Mich.
Allan M. Lansing, M.D., Louisville
Irwin Hanenson, M.D., Cincinnati, Ohio

Kentucky Industrial Medical Association
Room 203, Convention Center

2:00 "Alcoholism and Its Relationship to Employment"
Marvin A. Block, M.D., Buffalo, N.Y.

Kentucky Chapter,
American College of Physicians
Room 204, Convention Center

2:00 "Methotrexate Therapy in Advanced Gastro-Intestinal Malignancy"
Will W. Ward, Jr., M.D., F.A.C.P., Louisville

2:30 "Recent Advances in the Treatment of Renal Diseases"
Sidney G. Marcum, M.D., Louisville

3:00 Intermission to Visit Exhibits

3:30 "The Current Concepts of Insulin Secretion"
David M. Kipnis, M.D., F.A.C.P., St. Louis, Mo.

4:00 "Pacemaker Clicks"
Henry W. Post, M.D., Louisville

Kentucky Society of Pathologists
Room 208, Convention Center

2:00 "The Clinicians' Requirements for Emergency Laboratory Work"
Irving Kanner, M.D., Lexington

2:15 "The Referral Laboratory—Its Role and Responsibilities in the Delivery of Medical Laboratory Services"
Raymond F. Hain, M.D., Oklahoma City, Okla.

MARVIN A. BLOCK, M.D.
Buffalo, New York



Assistant professor of clinical medicine, State University of New York at Buffalo, School of Medicine. M.D., 1925, State University of New York at Buffalo. Vice president, American Medical Society on Alcoholism. Member, A.M.A.'s Committee on Alcoholism and Drug Dependence of the Council on Mental Health. Chairman, Subcommittee on Alcohol and Drugs of the President's Committee on Traffic Problems. Member, Board of Directors, International Institute of Alcohol and Alcoholism, Geneva.

VERNON N. HOUK, M.D.
Atlanta, Georgia



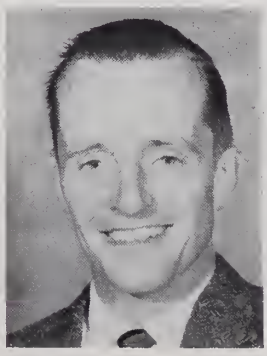
Deputy chief, Tuberculosis Program, National Communicable Disease Center. M.D., 1954, George Washington University School of Medicine. Fellow, American College of Chest Physicians, American College of Physicians. Former member, ATS Committee on Biologic Standards for Discharge of TB Patients. Former representative to the National Tuberculosis Association Committee for the Guidance of the Tuberculosis Program.

GEORGE F. BROCKMAN, III, M.D.
Greenville, Kentucky



An internist who has practiced in Greenville since 1946. M.D., 1935, University of Louisville School of Medicine. Past president of KMA and member of numerous committees in the Association. Chairman, Kentucky Tuberculosis Study Committee, Comprehensive Health Planning Committee. Active in the AMA Volunteer Physicians for Vietnam Program.

THOMAS S. MOULDING, JR., M.D.
Denver, Colorado



Assistant professor of medicine, University of Colorado School of Medicine. M.D., 1952, Northwestern University. Coordinator, U.S.P.H.S.-sponsored Tuberculosis Training Project in Denver. Fellow, American College of Physicians. Member, Committee for the Guidance of Tuberculosis Programs of National Tuberculosis and Respiratory Disease Association, American Public Health Association.

3:00 Intermission to Visit Exhibits

3:30 "Blood Gases in Cardiopulmonary Emergencies"
Linda Walters, M.D., Lexington

4:00 "The Failure of the Microbiology Laboratory to Assist In Emergency Situations"
Marvin Murray, M.D., Ph.D., Louisville

Kentucky Association of Public Health Physicians
Room 207, Convention Center

2:00 "Priorities in Tuberculosis Control"
Thomas Moulding, M.D., Denver, Colo.

2:30 "Role of Clinic in Prevention and Control"
Vernon Houk, M.D., Atlanta, Ga.

3:00 Intermission to Visit Exhibits

3:30 Questions and Answers
Thomas Moulding, M.D., Denver, Colo.
Vernon Houk, M.D., Atlanta, Ga.

4:00 (To Be Announced)
William McElwain, M.D., Frankfort

Kentucky Chapter,
American College of Surgeons
Room 104, Convention Center

2:00 "Pulmonary Contusion—Fact and Fantasy"
J. Kent Trinkle, M.D., Lexington

2:15 "Conservation Surgery for Pilonidal Disease—An Infectious Granulomatous Foreign Body Process"
Howard Dorton, M.D., Lexington

2:30 "Present-Day Risk of Thoracotomy in Patients with Compromised Pulmonary Function"
Lester R. Bryant, M.D., Lexington

2:45 "Parenchymal Hamartoma of the Liver in Infancy"
Robert C. Tate, M.D., Louisville
B. K. Chacko, M.D., Louisville

3:00 Intermission to Visit Exhibits

3:30 "Parenteral Alimentation Therapy in Surgical Patients"
Robert N. McClelland, M.D., Dallas, Texas

RICHARD B. McELVEIN, M.D.

Lexington, Kentucky



Assistant clinical professor of surgery, University of Kentucky College of Medicine. M.D., 1951, Tufts University School of Medicine. Thoracic and cardiovascular surgery practice in Lexington. Member, Southern Thoracic Surgical Association, Society of Thoracic Surgeons. President, Fayette County Medical Society.

JEROME W. CONN, M.D.

Ann Arbor, Michigan



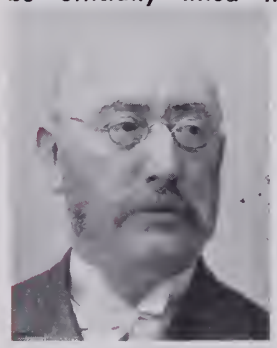
Louis Horry Newburgh Distinguished University Professor of Internal Medicine, Director of the department of endocrinology and metabolism and the Metabolism Research Unit, University of Michigan Medical School. M.D., 1932, University of Michigan. Member, World Health Organization, Geneva, expert consultant in chronic degenerative disease. Recipient, International Stouffer Prize and Gold Medal for Research in Hypertension. Author of 345 publications in the field of metabolism, endocrinology and hypertension.

4:00 "Reconstruction of the Anterior Abdominal Wall After Radical Surgery."
E. Truman Mays, M.D., Louisville
Sam D. Weakley, M.D., Louisville

4:15 "Blunt Abdominal Trauma in Children"
Robert P. Belin, M.D., Lexington

1970 Annual Meeting to Honor Past President Ouchterlony

The 1970 Annual Meeting of the KMA will be officially titled the J. A. Ouchterlony Memorial Meeting in remembrance of the 1890 president of the Association.



The tradition of honoring a past president of KMA or some distinguished physician each year at the Annual Meeting was started in 1935.

KMA Historian, Eugene H. Conner, M.D., Louisville, has written an interesting biography of Doctor Ouchterlony for the Annual Meeting program booklet, which will be distributed at the meeting in Louisville, September 22-24.

Scientific Program To Include Discussion On Timely Topics

Scientific presentations that are stimulating and informative will be featured at the four general sessions of the 1970 KMA Annual Meeting, September 22-24. Guest speakers from all parts of the country will join Kentucky physicians in discussions on "Emergencies," "Cardio-Pulmonary Resuscitation," "Industrial Medicine" and "Tuberculosis."

The Crackerbarrel Session, which was initiated at the 1969 meeting, will again be held at the Wednesday afternoon session and will feature many individual informal discussions.

In addition to the scientific sessions, the Annual Meeting will include meetings of the 16 Specialty Groups, meetings of the House of Delegates of KMA the President's Luncheon, an Orientation Program for new members, 75 technical exhibits and 11 scientific exhibits, the annual KEMPAC Seminar, and the Annual Convention of the Woman's Auxiliary to KMA.

President's Luncheon To Feature Author's Talk, KMA Awards

An address by Ralph Lee Smith, author of "At Your Own Risk" and the presentation of KMA's three top awards are two highlights of the President's Luncheon for physicians and their wives on September 23.

Mr. Smith will discuss "I Get the Treatment" at the luncheon held at 11:50 a.m. in the Flag Room of the Kentucky Hotel. Preceding his talk, the Distinguished Service Medal, the Outstanding General Practitioner Award and the R. Haynes Barr Award will be presented.

Well known for his book exposing chiropractic, Mr. Smith has authored several other books including "The Health Hucksters" and "Getting To Know the World Health Organization." In 1963 he received the Russell L. Cecil Distinguished Medical Writing Award from the Arthritis Foundation and in 1965, the American Medical Association Medical Journalism Award, Magazine Category.

The Awards Committee will present its nominations for the Distinguished Service Medal and the Outstanding General Practitioner Award to the House of Delegates at its first session. Other nominations may be made from the floor. Nominations may be mailed now to KMA Headquarters Office. The recipient of the R. Haynes Barr Award is selected by the Awards Committee, chaired by Richard F. Grise, M.D., Bowling Green.

The Awards Committee members are Doctor Grise, William A. Blodgett, M.D., Louisville; Frank L. Duncan, M.D., Monticello; C. Wayne Franz, M.D., Ashland, and Douglas E. Scott, M.D., Lexington.

1970 Annual Meeting To Feature Eleven Scientific Exhibits

Eleven outstanding scientific exhibits will be featured at the 1970 Annual Meeting, according to T. R. Marshall, M.D., Louisville, chairman of the Scientific Exhibits Committee.

Depicting recent developments in research and techniques, the exhibits will cover a wide range of medical topics. A certificate will be awarded each participating exhibitor and the exhibit honored as 1st-place will receive a plaque from KMA.

Conveniently arranged for easy access, the exhibits will be located between the Technical Exhibit Hall and the Scientific Assembly Hall in Convention Center. The eleven exhibits featured at this year's meeting are as follows:

Glaucoma Screening Booth
David McClure, M.D.
Kentucky Society for the Prevention of Blindness

Photography of the Eye
Walter R. Morris, M.D.

Treatment of Psoriasis with Hydroxyurea
Ullin W. Leavell, Jr., M.D.
John Yarbro, M.D.

Combined Ablative-Restorative Surgery for Head and Neck Cancer
Paul M. Weeks, M.D.
William Jewell, M.D.

Smoking in Causation of Respiratory and Upper Gastrointestinal Cancer
Condict Moore, M.D.

University of Kentucky Strabismus Cover Test Demonstrator
Jonathan D. Wirtschaffer, M.D.

Tetanus Immunization
William T. Rumage, Jr., M.D.

Man versus Arthropods
AMA Committee on Cutaneous Health and Cosmetics

New Developments in Gastrointestinal Examinations
T. R. Marshall, M.D.

Cytogenetics
Charles E. Hornaday, Jr., M.D.

Restoration of the Physically Disabled
Thomas A. Kelly, Jr., M.D.

U Of L Alumni Reunions Planned During KMA Annual Meeting

Alumni reunions are being planned for nine five-year classes of the University of Louisville School of Medicine during the 1970 KMA Annual Meeting, according to Les Shively of the Alumni office.

Individual functions are being planned for the groups by the chairman of each class. Following is a list of the chairmen selected this year.

1925—Arthur T. Hurst, M.D., 3337 Medical Arts Building, Louisville, 458-3259.

1930—Richard R. Slucher, M.D., 2202 Sieger Villa, Louisville, 452-1591.

1935—Mrs. Edwin (Vogt) Franz, 6201 Glenhill Road, Louisville, 425-6025.

1940—Edwin P. Scott, M.D., 400 Cornell Place, Louisville, 895-5401.

1945—Glen Pierce, M.D., 1919 State Street, New Albany, Ind., 945-6676.

1950—Hoyt D. Gardner, M.D., 508 Watterson City Building, Louisville, 452-2684.

1955—William H. Powers, M.D., 608 Medical Towers Building, Louisville, 584-0289.

1960—Robert McKechnie, M.D., 432 Wall Street, Jeffersonville, Ind., 282-1308.

1965—Robert A. Noel, M.D., 3612 Lexington Road, Louisville, 897-1871.

MESSAGE CENTER
584-2201

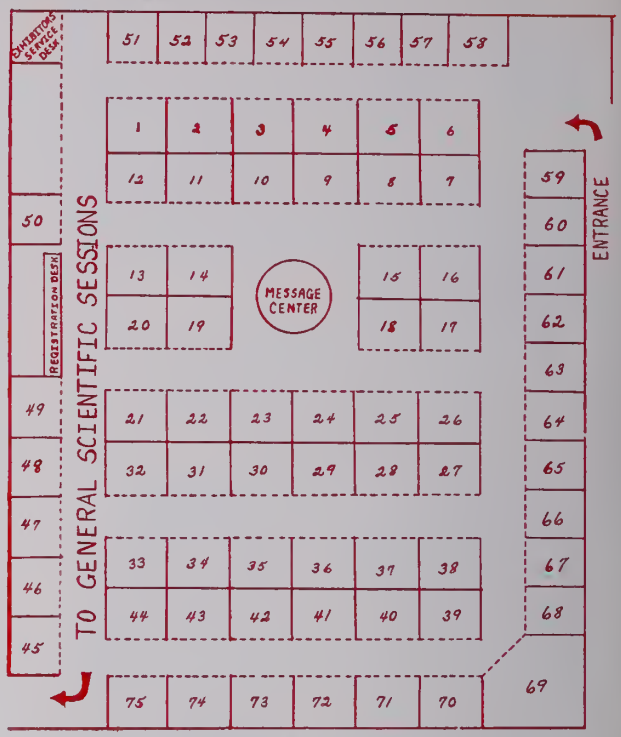
You may be reached through this number at the Convention Center during the KMA Annual Meeting September 22-24.

Latest Research Advances in Products and Services Offered by 1970 Technical Exhibits

The 75 technical exhibits at the 1970 Annual Meeting will feature the latest developments in medical techniques and information. The exhibits, located in the spacious hall at Convention Center, will condense an encyclopedia of ideas, discoveries and up-to-date advances in such a manner that a vast amount of knowledge and information can be secured conveniently and effortlessly in a short period of time.

Prepared carefully and skillfully to appeal to you, the physician, the exhibits have also been prepared to appeal to your special interests as a practitioner. Medical Representatives and other exhibitors will be on hand to discuss personally their products and services with you. Both you and your patients should benefit from the increased knowledge you will gain from a visit to the technical exhibits.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this excellent opportunity provided by the exhibits.



Floor Plan of Technical Exhibits

TECHNICAL EXHIBITORS

Abbott Laboratories (9)
American Medical Building Guild, Inc. (42)
Ames Company (59)
Arnar-Stone Laboratories, Inc. (57)
Automated Management Systems (36)
Ayerst Laboratories (21)
Bache Company, Inc. (37)
Blue Cross & Blue Shield, Kentucky (40)
Borden Inc., Pharmaceutical Products (46)
Bristol Laboratories (22)
Burroughs Wellcome & Co. (U.S.A.), Inc. (7)
Burton, Parsons & Company, Inc. (75)
Carnation Company (66)
CIBA Pharmaceutical Company (14)
Coca-Cola USA (69)
Dairy Council of Ky. & So. Ind., Inc. (64)
Dictaphone Corporation (60)
Doyle Pharmaceutical Company, D. M. (3)
Eaton Laboratories (50)
Emko Company, The (29)
Encyclopaedia Britannica, Inc. (62)
Field Enterprises Educational Corp. (67)
Gerber Products Company (56)
Guild of Prescription Opticians of Kentucky (10)
John Hancock Life Insurance Company (68)
Kay Surgical, Inc. (58)
Lakeside Laboratories, Inc. (30)
Lederle Laboratories (4)
Lee, A. P., Agency (65)
Lilly, Eli & Company (44)
Linden Laboratories, Inc. (71)
Lippincott, J. B., Company (5)
Lorillard Corporation (27)
Louisville Surgical Supply (41)
Malkin Instrument Company (17)
Mead Johnson Laboratories (16)
Medical Protective Company, The (63)
Merck Sharp & Dohme (45)
Merrell, The William S., Company (24)
Merrill Lynch, Pierce, Fenner & Smith, Inc. (70)
Meyer Laboratories, Inc. (25)
Mutual Benefit Life Insurance Co. (33)
North American Pharmacal (39)
Ortho Pharmaceutical Corporation (6)
Parke, Davis & Company (15)
Pepsi & Seven-Up Bottlers Association, Ky. (53)
Pfizer Laboratories (8)
Poythress, William P. & Company, Inc. (55)
Professional Corporation Benefits Company (72)
Ransdell Surgical, Inc. (47)
Reynolds, R. J., Tobacco Company (1)
Robins, A. H., Company (19)
Roerig, J. B., Division, Chas. Pfizer & Co., Inc. (38)
Rorer, William H., Inc. (32)
Ross Laboratories (12)
Sandoz Pharmaceuticals (23)
Saunders, W. B., Company (51)
Schering Laboratories (11)
Scroggins, Clayton L., Associates (31)
Searle, G. D. & Company (13)
Sheryl Pharmaceuticals, Inc. & Glencoe Research, Inc. (73)
Smith Kline & French Laboratories (20)
Smith, Miller & Patch, Inc. (18)
Squibb, E. R., & Sons, Inc. (43)
Stuart Pharmaceuticals, Div. Atlas Chemical Ind., Inc. (2)
Tele-Business Products Company (54)
United Medical Laboratories, Inc. (28)
Warner-Chilcott Laboratories (26)
Warren-Teed Pharmaceuticals, Inc. (48)
Winthrop Laboratories (49)
Wocher, Max & Son, Company (52)
Wyeth Laboratories (74)
Xerox Corporation (34 & 35)
Zimmer Manufacturing Company (61)

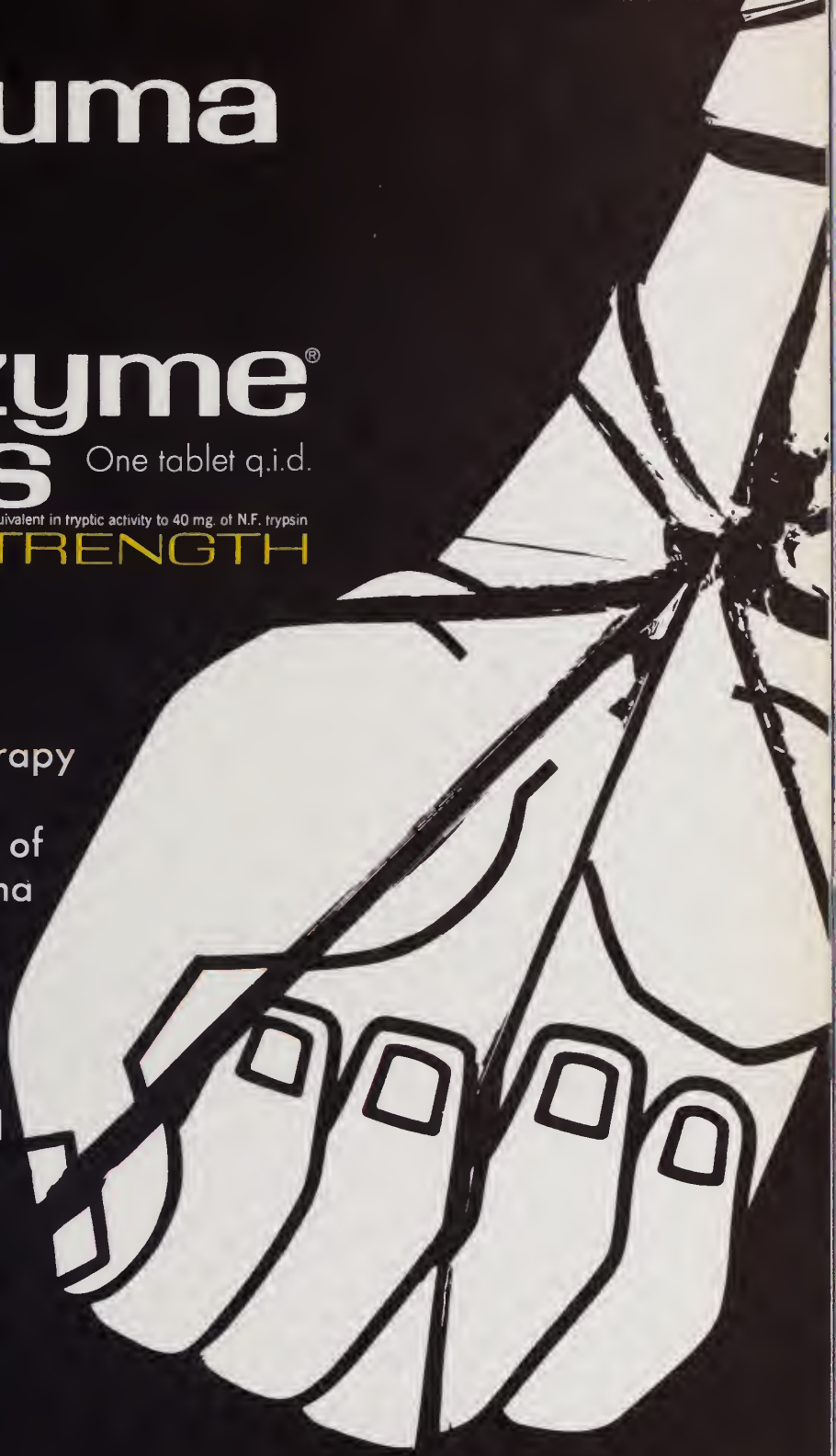
in trauma

new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.

A FULL DAY'S DOSAGE

Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

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Dosage: One applicatorful or ane suppasitary intravaginally ance ar twice daily.
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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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ORGANIZATION SECTION

Sept. 5 Is Deadline To Register For 1970 General Election

All seven Kentucky U. S. Representatives are to be elected in the 1970 General Election on Tuesday, November 3. The deadline for registering to vote prior to the election is September 5. Voter registration books have been open since June 1, 1970.

Candidates from the seven U. S. Congressional districts are: **1st,** Frank A. Stubblefield, (D-Murray), incumbent, to run unopposed; **2nd,** William H. Natcher, (D-Bowling Green), incumbent, to run unopposed; **3rd,** William O. Cowger, (R-Louisville), incumbent, to run against Romano L. Mazzoli (D-Louisville); **4th,** M. Gene Snyder, (R-Jeffersontown), incumbent, to run against Charles W. Webster, (D-Carrollton); **5th,** Tim Lee Carter, (R-Tompkinsville), incumbent, to run against Lyle L. Willis, (D-Corbin); **6th,** John C. Watts, (D-Nicholasville), incumbent, to run against Gerald G. Gregory, (R-Lexington); **7th,** Carl D. Perkins, (D-Hindman), incumbent, to run against Herbert A. Myers, (R-Louisa).

Family Practice Board Sets Second Exam Feb. 27-28

The American Board of Family Practice announces that it will give its second examination for certification in various centers throughout the United States. The examination will be held over a two-day period on February 27-28, 1971.

Information regarding the examination and eligibility for the exam can be obtained by writing: Nicholas J. Pisacano, M. D., Secretary-Treasurer; American Board of Family Practice, Inc.; University of Kentucky Medical Center; Annex #2, Room 229; Lexington, Kentucky 40506.

The deadline for receiving completed applications in the Board office is **November 1, 1970.**

Cancer Conference Scheduled

A National Conference on Cancer of the Colon and Rectum will be held at the Hotel del Coronado, San Diego, California on Thursday through Saturday, January 7-9, 1971. A broad multidisciplinary presentation of the rectal and colon cancer problem in the United States will be made by leading authorities in epidemiology, etiology, detection, diagnosis and treatment. Programs and approaches to control this disease will be discussed.

For information on this conference, which is being sponsored by the American Cancer Society, contact: Roald N. Grant, M.D., Vice President for Professional Education, American Cancer Society, 219 East 42nd Street, New York, N. Y. 10017.

Pharmacy School Marks Centennial

The first meeting of Louisville pharmacists to plan the establishment of a school of pharmacy was held July 28, 1870. This led to the creation of the Louisville College of Pharmacy which, in 1947, became the University of Kentucky College of Pharmacy. The College moved from Louisville to the Lexington campus in 1957.

The first Centennial Year event was held in conjunction with the annual meeting of the Kentucky Pharmaceutical Association July 19-22. A series of monthly Centennial Lectures are also scheduled.

Complete Details

of

1970 ANNUAL MEETING

on

Pages 523 - 545

★ KMA Officers and Delegates

★ Scientific Program

★ Orientation Program

★ Other Meeting Highlights

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grene and slough. This may be avoided by giving the antivenin I.V. within the initial 24 hour period.

Antivenin made from goat antiserum and human antiserum is available only at U.C.L.A. This is made from C. Atrox (Western Diamondback) and is not commerically available at the present time.

References

1. Block, M.J.: Function and operation of the facial pit of the pit vipers, *Nature,* 165: 284-85, 1950.
2. Andrews, et al: Venomous snake bite in Florida, *Journal of the Florida Medical Assoc.,* 55: 4, 318-326, April 1968.
3. S. A. Minton, Jr.: "Venoms" *Am. J. Trop. Med.,* 6: 1097-1107, 145-51, 1957.
4. Rhoten, Wm B.: Treatment of a bite of Mojave Rattlesnake, *Journal of Florida Medical Assoc.,* 55: 9, 338-340, April 1968.
5. Swaroop, S., Grob, B.: Snakebite mortality in the world *Bull. World Health Org.* 10: 35-76, 1954.
6. Klauber, L. M.: *Rattlesnakes, their habits, life history and influence on mankind,* Berkely, 1956, University of California Press, 867.
7. Gennaro, J. F., Jr.: Observations on Treatment of Snakebite in America in "Venomous and Poisonous Animals and Noxious Plants of the Pacific Region," 427-29, 1963.
8. Snyder et al: "Study of Snakebite," *Journal of the Florida Medical Assoc.,* 55: 4: 334, April 1968.
9. McCollough and Gennaro:
"Evaluation of Snakebite: *Journal of the Florida Medical Assoc.,* XLIX: 12: 959-967, June 1963.
10. Wilson, P.: Snake Poisoning in the United States, *Arch. Int. Med.,* 1: 516-570, 1908.
11. Borden, James, et al: Snake bite treatment by isolation perfusion technique, *Surgery,* 49: 303-307, 1961.
12 McCollough and Gennaro:
"Coral Snake Bites," *Journal of the Florida Medical Assoc.,* XLIX: 12: 968-972, June 1963.

(Continued from page 510)

pathy post-shunting and no evidence of deterioration of liver function at seven and ten months follow-up. In each case the splenic vein was tremendously dilated; hence, an adequate end-to-side anastomosis could be constructed. If the diameter of the splenic vein is less than two centimeters it is futile to attempt to construct an end-to-side shunt that will remain open for any length of time. When the splenic vein is small, a side-to-side anastomosis should be considered as advocated by Clatworthy and Boles[8] and Mason[9].

It is not necessary to use an extensive thoraco-abdominal incision to construct these shunts. A subcostal incision that extends into the flank laterally and across the mid-line medially is adequate and is associated with much less pain and discomfort than the thoraco-abdominal incision.

Some have suggested a two stage approach to patients with Banti's Splenomegaly and do a portacaval shunt to relieve the portal hypertension because they feel a larger anastomosis can be constructed. This has no effect on the hypersplenism and a subsequent splenectomy is necessary. Since these patients have dual pathology, we prefer a splenectomy and splenorenal venous shunt to control both the portal hypertension and esopageal hemorrhage and correct the anemia, leukopenia and thrombocytopenia as illustrated in our two cases.

References

1. Eck, N. V.: On the question of ligature of the portal vein, Voyenno—*Med Journal,* 130:1-2, 1877. (Translation *Surg, Gynec, and Obst,* 96: 375-376, 1953).
2. Lautenbach, B. F.: On a new function of the liver, *Phila Med Times,* 7: 387-394, 1877.
3. McIndoe, A. H.: Vascular lesions of portal cirrhosis, *Arch Path,* 5: 23-42, Jan, 1928.
4. Banti, G.: Splenomegalie mit lebercirrhose, *Beitr Path Anat Allg Path,* 24:21, 1898.
5. Dameshek, W.: Hypersplenism, *Bull New York Acad Med,* 31: 113-136, Jan, 1955.
6. Doan, C.A.: Hypersplenism, *Bull New York Acad Med,* 25: 625-650, Oct., 1949.
7. Linton, R. E., Ellis, D.S., Geary, J. E.: Critical comparative analysis of early and late results of splenorenal and direct portacaval shunts performed in 169 patients with portal cirrhosis, *Ann Surg,* 154: 446-459, Sept, 1961.
8. Clatworthy, H. W., and Boles, E. T.: Extrahepatic portal bed block in children: pathogenesis and treatment, *Ann Surg,* 150: 371-393, Sept, 1959.
9. Mason, E. E.: Splenectomy and side-to-side splenorenal shunt for portal hypertension. *Surg,* 60: 536-540, Sept, 1966.

Robert A. Beargie, M.D., is now on the faculty of the University of Kentucky College of Medicine. A 1957 graduate of the Ohio State School of Medicine, Doctor Beargie specializes in pediatrics. Before coming to Kentucky, he taught pediatrics at the University of Oklahoma.

William J. Collis, M.D. is now practicing ophthalmology and retinal surgery in Lexington. A graduate of the University of Louisville School of Medicine in 1961, Doctor Collis practiced retinal surgery in San Francisco before coming to Kentucky.

Victor J. Diorio, Jr., M.D. is practicing in association with Doctors Douglas, Peterson, Hale, Baker and Howard, Louisville. A radiologist, Doctor Diorio graduated from the University of Kentucky College of Medicine in 1965 and completed his residency at Indiana University Medical Center.

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In Memoriam

ALLEN B. CARTER, M.D.
Paintsville
1904-1970

Allen Burgess Carter, M.D., 66, died March 24. A 1931 graduate of the University of Tennessee College of Medicine, Memphis, Doctor Carter practiced general medicine in Paintsville. He belonged to the Johnson County, Kentucky and American medical associations.

MAX ERVIN, M. D.
Louisville
1926-1970

Max Ervin, M.D., 44, a Louisville anesthesiologist, died July 1. Doctor Ervin, a 1958 graduate of the University of Louisville School of Medicine, served as art director of the Jefferson County Medical Association's *Bulletin*. He was a member of the Jefferson County, Kentucky and American Medical Associations.

FRED T. HARNED, M.D.
Hopkinsville
1910-1970

Fred Turnley Harned, M.D., 59, died April 1. Specializing in otolaryngology and ophthalmology, Doctor Harned was a 1934 graduate of the University of Tennessee College of Medicine, Memphis. He was a member of the Kentucky and American medical associations.

LAWRENCE A. TAUGHER, M.D.
Louisville
1907-1970

Lawrence A. Taugher, M.D., 62, a Louisville physician, died July 7. Death was attributed to a stroke. A 1937 graduate of Ohio State University College of Medicine, Doctor Taugher is a past president of the Kentucky Chapter of the American College of Chest Physicians. Doctor Taugher specialized in internal medicine.

ALLAN F. ZOELLER, M.D.
Louisville
1925-1970

Allan F. Zoeller, M.D., 45, a Louisville orthopaedic surgeon, died June 6. Practicing in association with Doctors Fischer, Leatherman and Kotcamp, Doctor Zoeller graduated from the University of Louisville Medical School in 1948. From 1955 to 1957 he was assistant chief of orthopaedic surgery in the Armed Forces Orthopaedic Service of Europe.

Doctor Zoeller was a fellow of the American Academy of Orthopaedic Surgeons and belonged to the Kentucky Orthopaedic Association. He was an instructor of orthopaedic surgery at Veterans Hospital and the University of Louisville.

NEWS ITEMS

Darius Ghazi, M.D. is practicing orthopedic surgery in association with Charles Hoffman, M.D., Louisville. A 1962 graduate of the Tehran University Medical School, Doctor Ghazi completed his internship in Philadelphia and his residency training in Louisville.

Calvin R. Harding, Jr., M.D. is now in association with Doctors. White, Fleitz and Lee, Louisville. He received his M.D. degree from the University of Louisville School of Medicine in 1965 and completed his internship in Iowa and his residency training in Louisville. Doctor Harding specializes in anesthesiology.

Dorothy B. Suyemoto, M.D. is practicing with the Emergency Physicians' Service Group at Ft. Thomas. A 1949 graduate of the University of Michigan, Doctor Suyemoto's previous practice has been at Durham Hospital, Cincinnati.

Thomas R. Taylor, M. D. is now practicing in association with Robert Robbins, M. D., Elizabethtown. He received his M. D. at Emory University in 1960 and took his internship and residency at Fitzsimmons General Hospital. Doctor Taylor served in the U. S. Army from 1960-70 and is a Fellow in the American College of Surgeons.

George H. Kreyling, M. D. has started practice with Doctors Kumpe, Burger and Heringer of Covington. A 1963 graduate of the University of Cincinnati, Doctor Kreyling completed his internship and residency at Good Samaritan Hospital, Cincinnati and practiced there for two and a half years in internal medicine before coming to Covington.

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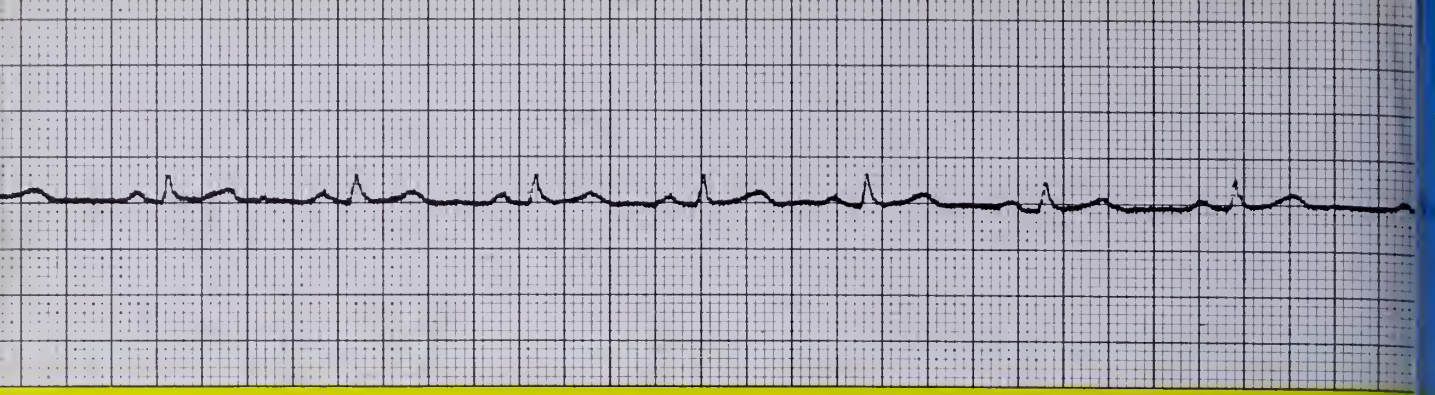
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Journal of The KENTUCKY Medical Association



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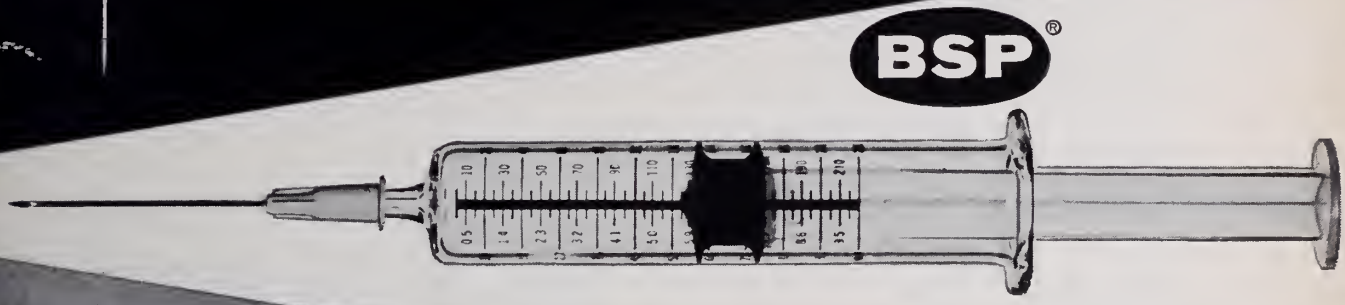
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Phone (Area Code 502) 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

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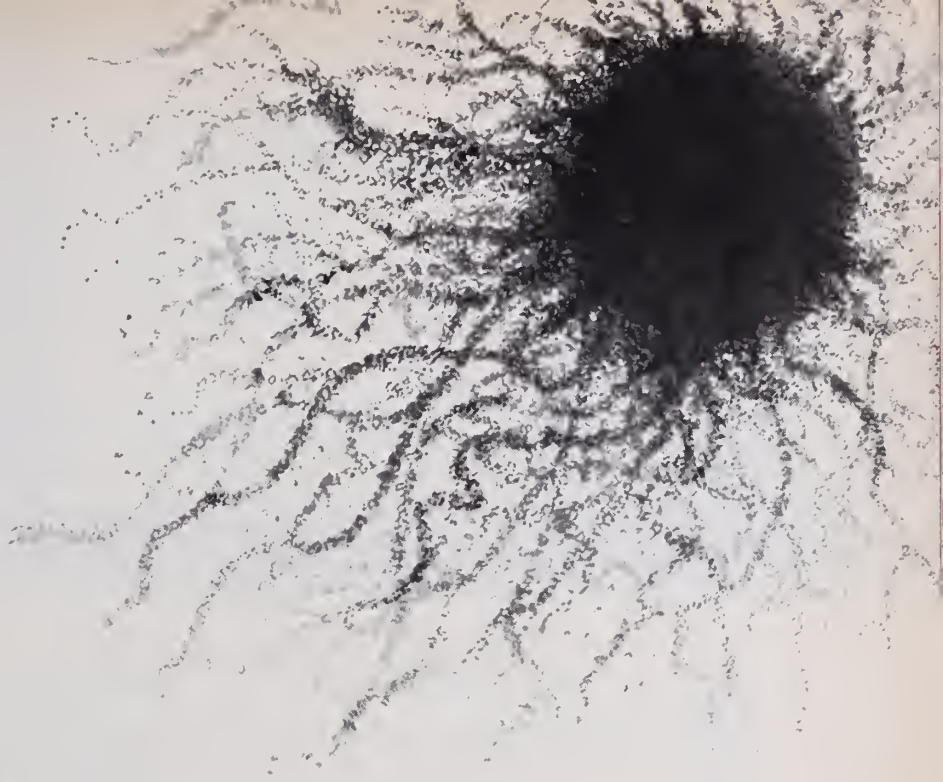
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

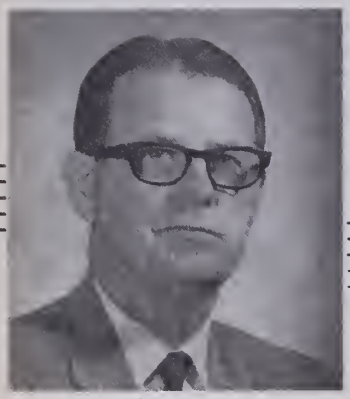
Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MESSAGE FROM THE PRESIDENT



1970 KMA Annual Meeting

September 22-24, 1970

THIS Annual Meeting affords physicians an opportunity for continuing medical education and relaxation. The headquarters will be in the Kentucky Hotel. Check now to see if you made your reservations. If not, please do it today. The Convention Center is conveniently located.

There are interesting scientific presentations for physicians of every field of medicine. Our guest speakers cover such topics as "Emergencies," "Cardio-Pulmonary Resuscitation," "Industrial Medicine" and "Tuberculosis." Good scientific exhibits await your viewing. Please make time available to visit with our technical exhibitors who have a variety of information that will be interesting to you. Those innovative Crackerbarrel Sessions cover large varieties of medical information. There is ample opportunity for small groups and individuals to consult and discuss medicine with knowledgeable physicians.

This is the only business meeting of the year for our House of Delegates. Consequently, it is advisable that you not only elect but actually send informed, responsible physicians as delegates. They speak for you. It behooves all the County Medical Societies to assure that they have representation at the Annual Meeting.

This issue closes out the President's Page for me. I wish to express humility and gratitude for the opportunities given me during the past year. Traveling about Kentucky and America gave me a chance to associate with many fine physicians, their families and allied medical personnel. These are trying times for our churches, our homes, our children and our country. We are concerned about drugs, the number and distribution of physicians and the rising cost of medical care. Medicine is under the gun. Take a deep and abiding interest in KMA so that you may better serve. As physicians we are fortunate to live busy, useful lives. To preserve your benevolent living requires you to become activists in KMA. To do otherwise permits the bureaucrats to push us into serfdom. To paraphrase the title of Thomas Wolfe's novel, we can't go home again. Indeed, we don't want to.

Walter L. Cawood

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Pri

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 14-68. This 22-year-old gravida 2, para 1, was admitted to the hospital via the emergency room. She had been having vaginal bleeding for the past eight days. When seen at 2:45 a.m., October 26, 1968, bleeding had increased with passage of bright red clots. Her first child was delivered at the same hospital, September 12, 1966.

No blood pressure was recorded when she was seen in the emergency room. She was able to sign the operative permit. No CBC was obtained, she was taken directly to the operating room for a D & C. IV pentothal was given. The operation began at 3:10 a.m. The cervical canal was described as "open", pieces of placental tissue were removed and packing was inserted. The patient began what was described as muscular twitching of her arms and legs. The pentothal was stopped at 3:16 a.m., she became cyanotic and no pulse was obtained. External cardiac massage was performed and artificial respiration was started with the Bennett machine. Intracardiac adrenalin was given. She expired at 3:50 a.m.

The pathology report was decidual and placental tissue. The cause of death was listed as incomplete abortion, cardiac fibrillation and arrest. There was no autopsy.

Comment

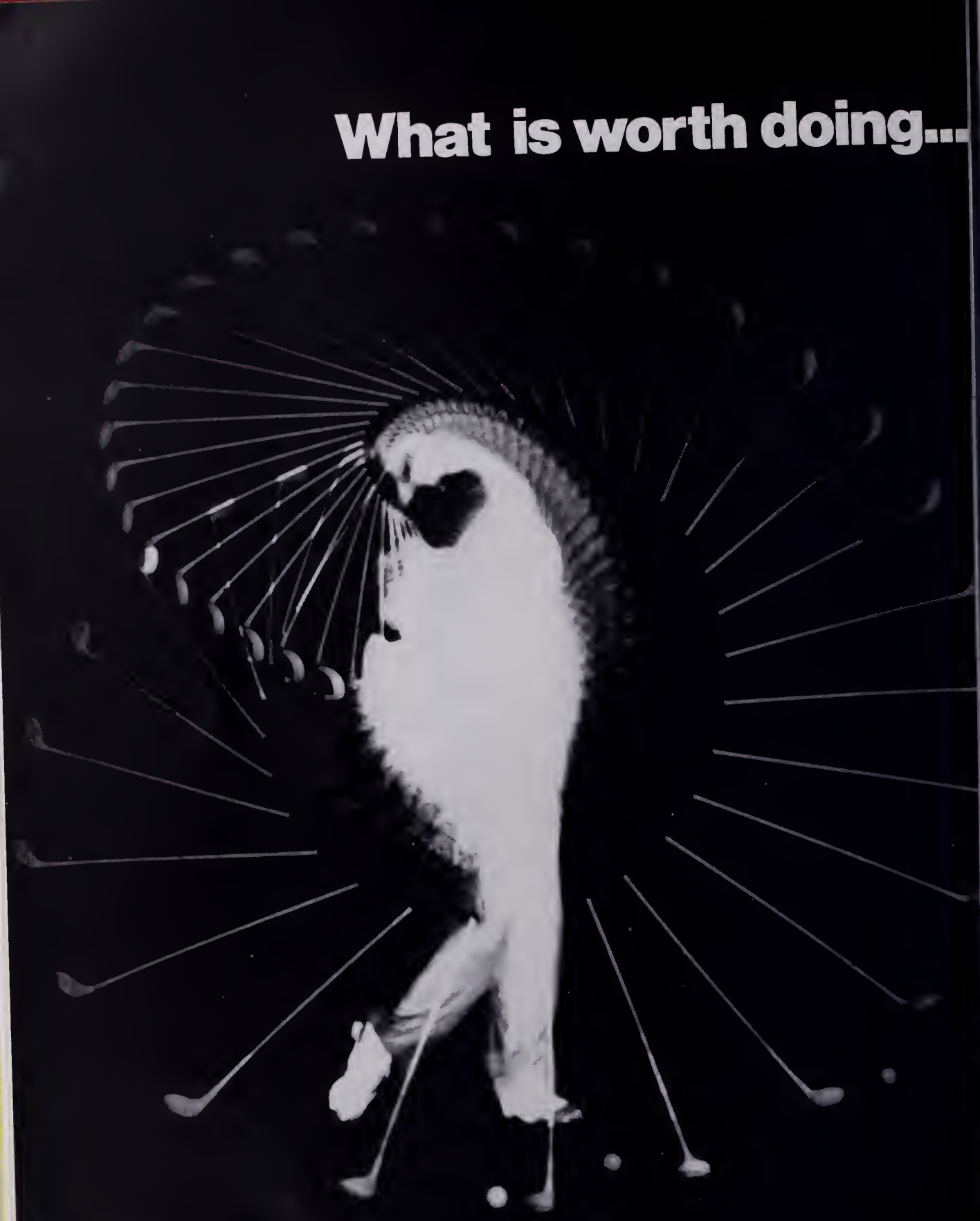
With the knowledge at hand, the Committee classified this case as obstetrical preventable; with preventable factors on the part of the patient and physician. This situation again demonstrates the value of postmortem examination to yield information as to the cause of death. But since it was not performed, the Committee discussed the following as possible factors contributing to death.

It is possible that the patient submitted to a criminally induced abortion with resulting infection, leading to a gram negative septicemia progressing to vascular collapse when she underwent the stress of anesthesia. In the care of a patient such as this it is essential to determine the blood count and monitor central venous pressure. Attempts to restore blood volume and establish an adequate blood pressure should have been carried out prior to submitting her to anesthesia and operation. No mention of an intravenous infusion of any sort is recorded. If infection were contributing to her condition, massive antibiotic therapy should have been initiated while restoring blood volume in preparation for evacuating the uterus. The status of renal function should have been determined by urinalysis and measuring the urinary output per hour.

The Committee discussed the possibility of death occuring due to anoxia due to laryngospasm following administration of pentothal, a common occurrence which must be properly treated. The question of using a Bennett machine was raised when it would have been best to establish an airway by giving a small dose of anectine (5.0 mg) and then giving positive pressure oxygen by mask, thereby maintaining proper pulmonary ventilation.

The patient was neglectful in that she apparently did not obtain proper medical care during the eight days prior to admission, when vaginal bleeding was present. Bleeding and/or infection must have been of significant proportion to render this 22-year-old woman in such a critical state. Proper care on the part of the patient and physician would seem to have rendered this death preventable.

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Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.
Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.
Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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PRECAUTIONS: As with other thyroid preparations, overdose may cause diarrhea or cramps, nervousness, tremors, tachycardia, insomnia and continued weight loss. These effects may become apparent in from 4 days to three weeks. Therefore, patients should be kept under close observation. Medication, in such cases, should be stopped for 2 to 6 days, then resumed at a lower level. In patients with diabetes mellitus, look for possible changes in metabolic activity which may affect insulin or other antidiabetic drug dosage requirements.

CONTRAINDICATIONS: Thyrotoxicosis, acute myocardial infarction.

SIDE EFFECTS: Side effects are secondary to increased rates of body metabolism: sweating, heart palpitations with or without pain, leg cramps, weight loss, diarrhea, vomiting and nervousness. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. In most cases, a reduction in dosage followed by a more gradual adjustment upward will indicate the patient's dosage requirements without the appearance of side effects.

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THE INSURANCE PAGE



The Committee Of 100

A recent press release by Leonard Woodcock, who followed Walter Reuther as head of the United Auto Workers and as chairman of the Committee of 100 for National Health Insurance, stated that there is a health care crisis in America. Woodcock said, "To many, the crisis boiled down to costs, but it will avail us little if we merely try to control costs and not deal with the true cause of the high costs: the chaotic disorganization of the present method of providing health care."

The proposals made by this Committee could radically change the way medicine is practiced today. The Committee includes 100 self-appointed labor leaders, self styled liberal-minded health experts, three U.S. senators and actor E. G. Marshall. If the proposals announced by the Committee were passed by Congress it would mean an end to private health insurance plans and Medicare and Medicaid.

Members of the Committee for National Health Insurance do not expect Congress to buy their plan entirely—especially in view of the almost certain opposition it will receive from organized medicine.

Under the plan, a health security trust fund would be created from general tax revenues, tax on employer payrolls and individual income tax. For that money, Americans would get all their doctor bills paid.

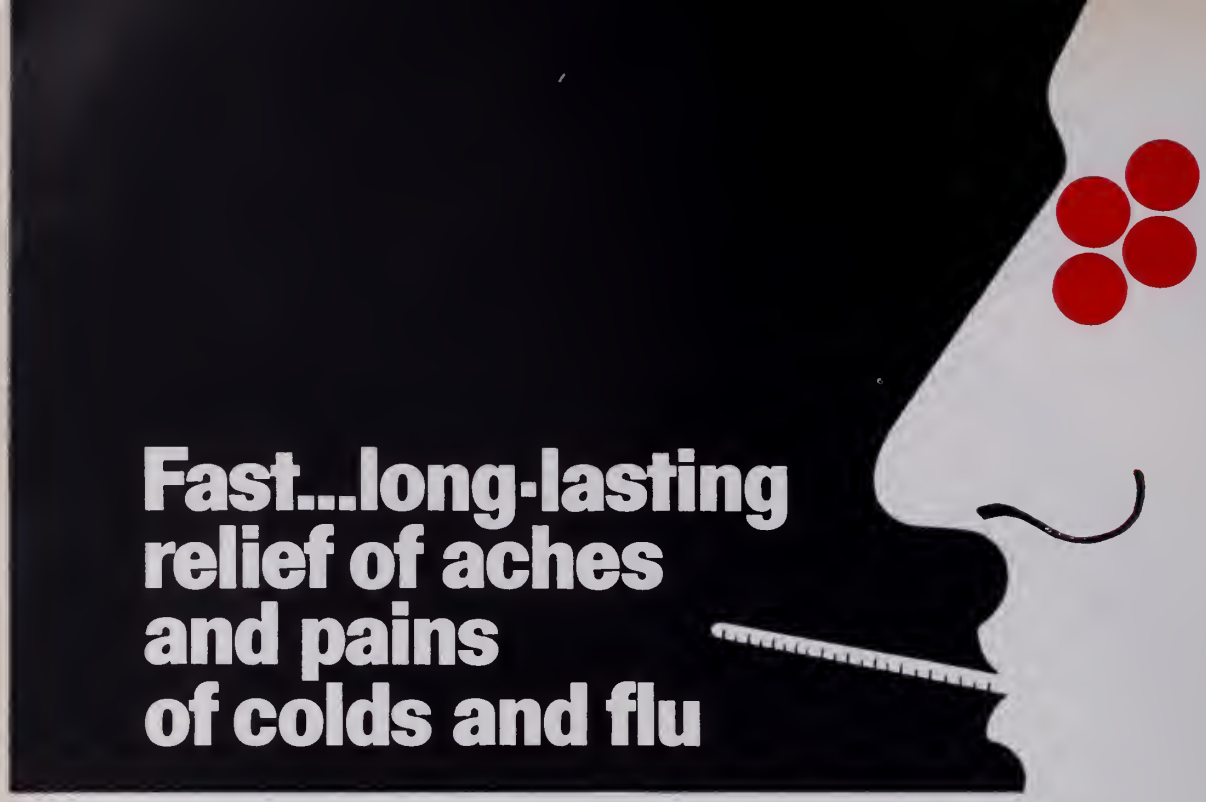
Yet there seems to be some exceptions put forward by the Committee. It would seem that only the doctor bills would be paid that the Committee approved. For instance, major operations and specialized treatments will be covered only if qualified specialists do it. One wonders if the government is going into the business of qualifying medical specialists, or does the Committee wish to judge the qualifications of an individual's attending physician. Apparently the individual will have no choice of physicians, unless he chooses to pay this tremendous tax burden and then pay for his medical care from his own pocket.

The Committee is to be commended in that they recognize that psychiatric services should be fully covered, yet they limit coverage for psychiatric service by stating that there would be only limited coverage paid to an individual psychiatrist, regardless of his qualification as a specialist. In order to be fully covered, psychiatric services must be received as part of a comprehensive health program given in a hospital or a community mental health center approved by the government. The psychiatrist in these centers will be qualified as a specialist merely by the fact that he is employed by a government approved agency.

The writer would like to quote from a news release in the Louisville Courier-Journal, "In another effort to encourage new ways of treating the patients, drugs would be covered if prescribed by hospitals or group practice plans." Either the newspaper made a typographical error, or the Committee of 100 planned to change all of the state laws which license only individuals to practice medicine and to prescribe drugs. No hospital or corporation at present is licensed to practice medicine and it is not conceivable that anyone other than a graduate of an approved medical school will be licensed to practice medicine. Hospitals and corporations are not graduates of medical schools.

Apparently the Committee of 100 wishes to establish the medical profession as cogs in a giant assembly line which will turn out treated patients much the way that the Detroit factory turns out automobiles.

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surgical operations were performed and when there were practically no drugs available for specific treatment. Medical knowledge has advanced much more rapidly than the means to dispense medical treatment. Today medical treatment has become complex, but much more effective than treatment available two decades ago. It is also much more expensive.

The Committee of 100 is undoubtedly moved by concern for their fellowman, in that they wish to legislate the best scientific care for every American. Unfortunately one cannot legislate this type of medical care until there are enough highly trained medical specialists and ancillary medical personnel available to dispense this care. What does the Committee propose to do about rural areas where there is only one physician? Will this physician be part of a group practice plan in a distant city? Will he be paid according to the number of hours he works, or will he be paid a salary by the group practice plan? Will this physician be willing to work long hours, or will automation reduce him to a 40-hour week?

Apparently the Committee of 100 dreams of utopian medical care furnished in the highly industrial city setting. America is a great land with varied types of population in many different community settings. It will be indeed difficult to legislate medical care for the whole country.

If the Federal government wishes to insure that each American gets good medical care, they must first legislate means for increasing the number of skilled physicians and ancillary medical personnel.

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ANSWERS TO YOUR QUESTIONS ABOUT BLUE SHIELD

Q. Are all Federal Employee Program subscribers who have Blue Shield enrolled in the Usual and Customary Program?

A. *Federal Employees have the option of choosing between two levels of Blue Shield benefits. Low Option is an indemnity surgical schedule (Not Usual and Customary) and is identified by the Enrollment Code Numbers 104 (single) and 105 (family). High Option Federal Employee Program subscribers have Usual and Customary Blue Shield and are identified by the Enrollment Code Number 101 (single) and 102 (family.) These identifying numbers appear in the lower left on the member's identification card.*

Q. Does the Usual and Customary Participating Physician Agreement apply to all Blue Shield contracts?

A. *No. The Usual and Customary Participating Physician Agreement applies only to the Usual and Customary Program and does not affect the Blue Shield Indemnity contracts.*

Q. How often are the Usual and Customary guidelines reviewed and updated?

A. *The 1969 KMA House of Delegates requested Blue Shield to review the Usual and Customary guidelines at least annually with the assistance of a Peer Review Committee, however Blue Shield is presently reviewing and updating the Usual, Customary and Reasonable guidelines quarterly.*

Q. What happens when a Usual and Customary claim cannot be processed routinely?

A. *When a claim is incomplete, or if the fee submitted is beyond the point of routine payment, a letter is sent to the attending physician asking if there were any extenuating circumstances involved and if so, requesting the physician to furnish additional information. When additional information is presented, the case is given further consideration and may, at this point, be paid. If, however, the claim is still not resolved, it will be referred to a Professional Relations Representative for a personal contact with the physician. In his visit the Professional Relations Representative will:*

A. *Seek additional information which could help determine payment.*
B. *Explain and discuss the mechanisms of the Usual and Customary Program.*
C. *Explain the referral of the case to the appropriate peer review committee (if needed.)*

It is the responsibility of the appropriate review committee to recommend a reasonable allowance for the service rendered based on the information available and with consideration given to any additional information provided by the physician.

Q. How many physicians are now "participating" in the Blue Shield Usual and Customary Program?

A. *As of July 1, 1970, over 75 per cent of all active practicing physicians in Kentucky have signed Participating Physician Agreements for the Blue Shield Usual and Customary Program. Fifty-five counties are 100 per cent participating.*

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See Clinical Considerations section on last page...

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ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	Less Severe 0.8-1.2 mg./kg. for 7-10 days	Resistant/ Moderately Severe Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	Serious/Life-Threatening up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in in dividuals with a history of hypersensitivity or toxic reactions t gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whon serious infection develops, serum concentrations of the drug ma rise, with consequently increased risk of ototoxicity. In these pa tients or in those in whom recommended dosage or duration o therapy must be exceeded as a life-saving measure, routine studie of kidney function should be performed when possible. These ma be supplemented by evaluation of the vestibular and auditory func tion and measurement of serum concentration of the drug whe feasible. Serum concentrations of gentamicin should be maintaine below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 1 days or be repeated unless required for serious infection not re sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectabl may occasionally result in overgrowth of nonsensitive organisms. I superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity o nephrotoxicity have not been established. Studies in pregnant ani mals have not revealed teratogenic or ototoxic effects in the fetus GARAMYCIN Injectable should not be used in pregnant patients o in women of childbearing age unless its use is deemed advisabl by the physician.

Adverse Reactions: The overall incidence of ototoxicity considere related to treatment with GARAMYCIN Injectable was 2.8 per cen (16 of 565 patients). Contributory factors (two or more factors wer relevant to most patients) were as follows: 10 had azotemia, 1 received a total of 1 gram or more of the drug, 7 had recently re ceived other potentially ototoxic antibiotics (streptomycin or kana mycin), and 5 were over 60 years of age. Six also had decrease high-tone hearing acuity, which returned to or toward normal i the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showe increases in BUN that were probably related to treatment wit GARAMYCIN Injectable. Of 20 increases probably or possibly relate to treatment, 7 were reversible, 9 occurred in terminal patients, an 4 had no follow-up.

Other adverse reactions associated with treatment were one instanc each of urticaria, decreased hematocrit, and reversible depressio of granulocytes with normal bone marrow. Other rarely reporte and possibly treatment-related adverse reactions were anemia, in creased reticulocyte count, rash, purpura, drug fever, hypotensio convulsions, twitching, salivation, nausea, vomiting, increased trans aminase activity (SGOT or SGPT), increased serum bilirubin, de creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dos vials, for intramuscular administration.

For more complete prescribing details, consult package insert o Physicians' Desk Reference. Schering literature is also availabl from your Schering Representative or Medical Services Departmen Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28 S-02

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

SEPTEMBER

16 PANMED television series, "Drug Information," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

16-19 Emergency Care and Transportation of Sick and Injured Persons advanced course, University of Kentucky, Lexington

17-19 Postgraduate course, "Pulmonary Function Tests in Management of Chest Disease," University of Kentucky Medical Center, $35 fee.

22-24 Annual Meeting, Kentucky Medical Association, Convention Center, Louisville

23 PANMED television series, "Clinical Use of Electrical Pacemakers," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

30 PANMED television series, "Exercise and the Heart," KETV-TV 9:30 p.m. EDT (8:30 p.m. CDT)

OCTOBER

17 Annual Meeting, Kentucky Chapter, American College of Physicians.

17-18 Postgraduate course, "Clinical Demonstration of Common Skin Problems," University of Kentucky Medical Center, $30 fee

23-24 Postgraduate course, "Listening, Deciding, Doing," University of Kentucky Medical Center, $60 fee

23-24 Fall Conference, Kentucky Thoracic Society, Boone Tavern Hotel, Berea

NOVEMBER

5-6 Fourth Annual Newborn Symposium, University of Louisville School of Medicine, Louisville.

IN SURROUNDING STATES

SEPTEMBER

10-12 Annual Meeting, American Association of Obstetricians and Gynecologists, Hot Springs, Va.

25-26 The American College of Physicians (Tennessee Regional), Ramada Inn, Knoxville

25-Oct. 1 Annual Meeting, American Academy of General Practice, San Francisco, Calif.

OCTOBER

4 Council on Environmental and Public Health, Roosevelt Hotel, New Orleans, La.

5 Annual Meeting, American Academy of Ophthalmology and Otolaryngology, Dunes Hotel, Las Vegas, Nev.

12-16 Clinical Congress of American College of Surgeons, the Conrad Hilton Hotel, Chicago, Ill.

14-16 Cleveland Course in Pulmonary Disease, St. Luke's Hospital, Cleveland.

25-29 Fall Scientific Assembly, American College of Chest Physicians, Century Plaza Hotel, Los Angeles.

NOVEMBER

11-12 Postgraduate course, "Diagnostic Procedures in Gastroenterology," Cleveland Clinic Educational Foundation, Cleveland

16-19 Annual Meeting, Southern Medical Association, Dallas

29-Dec. 2 Clinical Convention, American Medical Association, Boston

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can to avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Ephraim McDowell Drive, Louisville, Ky. 40205.

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Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

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The JOURNAL of the
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ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 68 SEPTEMBER 1970 No. 9

The Fallacy of Insulin Adjustment By The Sliding Scale

DUNCAN ROBERT MACMILLAN, M.D.*

Louisville, Kentucky

It is the purpose of this communication to point out some of the practical, as well as the theoretical, objections to the sliding scale method of insulin adjustment.

CALCULATION of insulin dosage in the newly diagnosed or poorly controlled juvenile diabetic by means of a sliding scale, based on urinary glucose concentration, is widely practiced and is advocated in several prominent texts and references[1-3]. The sliding scale dictates a specified number of units of insulin for each "plus" of the Clinitest (Ames) reaction, so that current glycosuria is the sole determining factor in the calculation of the insulin dose. Basing the insulin dosage solely on the response to the previous dose, and ignoring such important considerations as the amount and effect of the corresponding doses on previous days, and the anticipated needs of the ensuing six to eight hour period, would certainly seem to be an unsound practice.

While the obvious shortcomings of the sliding scale method have led to the discontinuation of its use in many leading centers, little overt criticism of the method has appeared in print[4] and it continues to be widely used.

Methods

To evaluate the efficacy of the sliding scale method, and the possible difficulties associated with its use, data on all newly diagnosed diabetics admitted to the Children's Hospital, Louisville, Kentucky, during the years 1961-1967 were reviewed. Cases in which initial control was attempted using regular insulin, prescribed according to a sliding scale, were compared with those in which modified insulin was introduced in the first 24 hours of insulin therapy. Cases presenting in significant acidosis requiring aggressive therapy with regular insulin and intravenous fluid therapy were excluded from the study to insure that the two groups were of comparable severity at time of initiation of insulin treatment. Cases treated with regular insulin prescribed with all pertinent information being taken into consideration [5, 6], or with a sliding scale superimposed on a basic dose of regular insulin[7], were too few to afford meaningful comparisons.

Urine glucose was determined by the Clinitest (Ames) method on fractional urine specimens before each meal and at bedtime. Patients showing a clinitest reaction of 2-plus or less in all four fractional urine specimens over a 24-hour period were considered as "controlled" for the purposes of this study. The presence of ketosis was indicated by the Acetest (Ames) reaction performed on fractional urine specimens.

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Patients on regular insulin exclusively received insulin four times daily, before meals and at bedtime, while patients receiving modified insulin received either a single pre-breakfast injection or, more frequently, injections prior to both breakfast and the evening meal. Initial daily dose in the latter group was approximately one unit per kilogram of body weight, while the usual sliding scale schedule called for five units for every "plus" of the Clinitest reaction in the older children with some scaling down of dosage in smaller patients.

Results

Twenty-seven ketotic, non-acidotic cases were treated with an extended course of regular insulin therapy, prescribed according to a sliding scale based on current glycosuria. Results are compared with those of 14 similar cases treated early with modified insulin (Table I). The two groups were comparable in terms of initial blood sugar and length of stay. Ketosis persisted over 50 per cent longer in the sliding scale group. This was attributable to a recurrence of "moderate" or "large" acetonuria in 44 per cent of cases in this group when insulin was omitted during periods of aglycosuria, as dictated by the sliding scale.

Regular insulin was used exclusively for an average of almost five days in the sliding scale group, with control being achieved in only 26 per cent before introduction of modified insulin. Control was achieved with modified insulin in only one-third of this group, while over three-quarters of the group in which modified insulin was introduced early came under control.

Hypoglycemia was observed more frequently in the modified insulin group (36 per cent) but was mild and late in the course of hospitalization, associated with attainment of control. Hypoglycemia was recorded in 11 per cent of cases on regular insulin alone, but it is interesting to note that a maximum dose of insulin given for 4-plus glycosuria at bedtime very frequently resulted in a swing to aglycosuria in the pre-breakfast specimen. One of these children experiencing his first documented insulin reaction volunteered: "This is the way I feel every night." Nocturnal hypoglycemia may have been missed in other cases.

Discussion

In this group of patients, attempts to establish diabetic control using regular insulin prescribed according to a sliding scale for urine glucose were futile in the majority of cases. In fact, the delay in instituting definitive insulin therapy seemed to prejudice chances of obtaining control with modified insulin during the usual period of hospitalization.

Difficulty in establishing control with regular insulin, using the sliding scale, was frequently related to establishment of a pattern of too much insulin alternating with too little. Excessive doses of insulin were often given for 4-plus glycosuria and the following doses omitted because of resulting aglycosuria. Omission of insulin almost invariably resulted in recurrence of strong glycosuria and return to the original dose and frequently to repetition of the cycle. As has been observed by Traisman and Newcomb[8], omission of insulin when glycosuria ceases frequently results in return of

TABLE I

KETOTIC CASES WITHOUT ACIDOSIS

Initial Insulin Therapy	Number of Cases	Average Initial Blood Sugar	Average Duration of Ketosis	Average Duration of Regular Insulin Therapy	Number of Cases Controlled on Regular Insulin	Number of Cases Controlled on Modified Insulin	Average Length of Stay
Regular "sliding scale"	27	346	36.7 hrs.*	4.9 days	7 (26 %)	9† (33.3 %)	12.3 days
Early Long Acting	14	347	22.3 hrs.*	....	....	11† (78.6 %)	12.3 days

**Difference in duration of ketosis is statistically significant. ($p < 0.05$)*

†A test of the equality of the proportions 11/14 and 9/27 yielded a Z value of 2,712. This is significant at the 0.01 level.

acetonuria and represents a major cause of prolongation or recurrence of ketosis. While caution must be used in administering insulin to the aglycosuric patient, disappearance of sugar from the urine in the ketotic patient is an indication for increased glucose intake and not a suspension of the program of insulin administration.

Conclusions

In the analyses of these cases severe shortcomings of the sliding scale method of regular insulin adjustment were evident. Establishment of control with regular insulin was infrequently achieved when a sliding scale was used for dosage calculation. Omission of insulin when glycosuria ceases is a major defect in the commonly used sliding scale method, and, in general, the size of the insulin dose is out of phase with the insulin needs of the patient.

It should be pointed out that the relative merits of early introduction of modified insulin and extended use of regular insulin, prescribed in a logical and scientific manner, are not examined in this study, nor is any criticism implied of insulin supplements prescribed according to a sliding scale based on acetonuria.

References

1. Etteldorf, J. N.: Metabolic Disturbances-Juvenile Diabetes Mellitus. In Hughes, J. G., ed.: *Synopsis of Pediatrics*. St. Louis: C. V. Mosby Co., p 580, 1967.
2. Campbell, R. A. and Jacinto, E. Y.: Metabolic Emergencies-Diabetes Mellitus. In Varga, C., ed.: *Handbook of Pediatric Medical Emergencies*. St. Louis: C. V. Mosby Co., p 466, 1968.
3. Moss, J. M.: Diabetes Mellitus in Adults In Conn, H. F., ed.: *Current Therapy*. Philadelphia: W. B. Saunders, p. 323, 1967.
4. Bondy, P. K.: Disorders of Carbohydrate Metabolism-Diabetes Mellitus in Bondy, P. K., ed: *Duncan's Diseases of Metabolism*. Philadelphia: W. B. Saunders, Vol. 1, p 226, 1969
5. Nelson, W. E.: Metabolic Disorders-Diabetes Mellitus. In textbook of *Pediatrics*. Philadelphia: W. B. Saunders Co., p 1155, 1969.
6. Jackson, R. L. and Pickens, J. M.: The Child with Diabetes. In Duncan, G. G., ed.: *Diseases of Metabolism*. Philadelphia: W. B. Saunders Co., p 1084, 1964.
7. Molnar, G. D.: Management of the Young Diabetic. In Conn, H. F., ed: *Current Therapy*. Philadelphia: W. B. Saunders Co., p 352, 1970.
8. Traisman, H. S. and Newcomb, A. L.: Six-Hour Management. In *Management of Juvenile Diabetes Mellitus*. St. Louis: C. V. Mosby Co., p 22, 1965.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in the Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.

Review of Thyroid Nodules At The University of Kentucky Medical Center†

L. Thomas Albert, D.D.S., M.D. and William R. Jewell, M.D.

Lexington, Kentucky

A series of 133 cases of thyroid nodules, of which 25 were carcinoma, is reviewed. When the thyroid nodule was associated with palpable cervical lymph nodes, the probability of thyroid carcinoma proved to be high.

In a retrospective study, all cases with thyroid nodules receiving surgical therapy were evaluated. During the period from May, 1962, to March, 1970, 133 cases were seen. Review of these records reveals the uncertainty of diagnosis by clinical parameters as surgery was generally necessary for a definitive diagnosis. The finding that 50 per cent of males with a solitary nodule were harboring carcinoma is most significant. The other findings in this review are generally consistent with the current literature.

Past History

As with most thyroid gland problems, women made up the vast majority of cases. Of the total number, 117 were women. The mean age at time of surgery for these women was 42 years. The range was from six years to 73 years of age. Seventy-three per cent of this group were from 31 to 60 years of age. Men composed 12 per cent of the total group, and their mean age at time of surgery was 40 years. Their ages ranged from five years to 67 years. Sixty-three per cent of the men were between the ages of 31 to 50 years (Table I). The sex ratio in papillary carcinoma was 2.3 women for each man with the disease. The mean age at time of diagnosis of papillary carcinoma was 38 years which is about the same as the mean of 39 years of age for diagnosis of follicular carcinoma. However, for each man with follicular carcinoma there were four women with this histologic type. Of the three patients with anaplastic carcinoma, two were women. The mean age at the time of diagnosis for these three patients was 62 years. The two patients with Hurthle cell carcinoma were women, both over 45 years old at the time of diagnosis.

Only two patients of the entire group received irradiation to the neck region as a child, and both of these patients had thyroid carcinoma. A man, who was found to have papillary carcinoma at 24 years of age, had received irradiation for hyperplastic adenoids. A 36-year-old woman with follicular carcinoma had received irradiation for a lateral cervical mass.

For the total group, an average of 7.5 years existed from the onset of the noticeable nodule to the hospital admission for surgical removal. The delay for patients with carcinoma was 2.3 years and 8.2 years for patients with benign disease. Patients with carcinoma were brought to surgery much sooner than those with nonmalignant lesions. Only four of those with carcinoma had a previous histologic diagnosis of carcinoma.

Many of these patients, including seven patients with carcinoma, received various types of treatment for their thyroid nodule prior to presenting at the University of Kentucky Medical Center. Twenty patients were treated with thyroid extract, and none had a decrease in the size of the nodule. One patient with follicular carcinoma was treated with thyroid extract as was the patient with the mixed tumor. Eleven patients were treated with iodide without response. Propylthiouracil was used in five cases. Methimazole was used in treatment of three patients with decrease in symptoms in one case. Two patients received synthyroid without response. One patient, who received antibiotics for the rapid onset of his thyroid nodule, had anaplastic carcinoma. Six patients with carcinoma had surgery prior to coming to UKMC. One patient with papillary carcinoma

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had a previous partial lobectomy. Another patient with follicular carcinoma had a previous partial lobectomy. Another patient with follicular carcinoma had received a previous subtotal thyroidectomy. One patient with Hurthle cell carcinoma had thyroid surgery of unknown type. A patient with anaplastic carcinoma had thyroid surgery of unknown type plus thyroid extract. Two patients without carcinoma had undergone subtotal thyroidectomy prior to coming to this medical center. One patient received 1500 rads three years before arriving at this center with known carcinoma which was diagnosed three years before the start of the irradiation. Two patients received propylthiouracil and SSKI to make them euthyroid for surgery.

The two cases with medullary carcinoma were family related. This family had a history of medullary carcinoma with neuroendocrine dysplasia. The case involving the 34-year-old man was diagnosed from liver metastases, whereas the five year old boy received a total thyroidectomy for prophylactic purposes. The thyroid specimen showed carcinoma. Both had thyroid scans showing uniform distribution, and both had clinically palpable cervical nodes. Biopsy of cervical nodes obtained from the adult demonstrated metastatic spread from the thyroid gland.

Physical Examination

In those cases where records of the nodule were made, 97 patients or 82 per cent had a solitary nodule. There were 22 patients recorded with multiple nodules. In patients with carcinoma, 13 had solitary nodules while three had multiple nodules. Nodular size ranged from that which was just palpable to the size of 10 by 10 cm. Four patients had nodules of the 10 by 10 cm. size. In patients with carcinoma, nodule size ranged from 1 by 1 cm. to 10 by 10 cm.

Clinically palpable, cervical nodes were discovered in 17 patients which is 12.8 per cent of the total group. Of the 25 patients with thyroid carcinoma, 52 per cent had clinically palpable, cervical lymph nodes. Of those 13 patients with carcinoma who had a cervical node dissection or cervical node biopsy, 62 per cent had metastatic changes within the cervical nodes. Each of the three patients with anaplastic type carcinoma had clinically palpable, cervical nodes. Of the 10 patients with papillary carcinoma, four had clinically palpable and histologically positive, cervical nodes. One of the 10 patients had histologic positive nodes but no clinically palpable nodes. None of the patients with follicular carcinoma had clinically palpable nodes, and those two patients who had neck dissections did not have histologically positive nodes.

Laboratory

Thyroid scans were recorded for 92 patients. Of these patients, 66 showed nodular hypofunction or a "cold" nodule, 20 had uniform distribution or a "warm" nodule, and six showed nodular hyperfunction or a "hot" nodule. In patients with carcinoma, 13 nodules were "cold", two were "warm" and one was "hot." The three carcinoma cases with multiple nodules were "cold."

TABLE I

AGE AND SEX GROUPING OF THYROID NODULES

Yrs.	Males	Yrs.	Female
1-10	1	1-10	1
11-20	1	11-20	9
21-30	1	21-30	11
31-40	4	31-40	32
41-50	6	41-50	33
51-60	1	51-60	20
61-70	2	61-70	8
71-80	0	71-80	3
	16		117

Only three patients showed indications of the thyroid disease spreading below the clavicle. All these patients had anaplastic carcinoma, and in every case the lungs were involved. In one of the three patients there was a bony radiolucency in one femur and erosion of several ribs. In two cases, the thyroid carcinoma was diagnosed from metastatic tissue. In one case, papillary carcinoma was diagnosed by a cervical lymph node biopsy. In the other case, medullary carcinoma was discovered by a liver biopsy.

Treatment

Operative procedures on this group numbered 134. Eighty per cent of these procedures consisted of lobectomy, lobectomy plus partial contralateral lobectomy and partial lobectomy. (Table II) Of those patients with papillary carcinoma, two had a lobectomy, two had a lobectomy plus a radical neck dissection, two had a total thyroidectomy plus radical neck dissection, two had a total thyroidectomy

plus modified neck dissection, one had a total thyroidectomy, and one had a total thyroidectomy plus bilateral radical neck dissection. The patient with a mixed carcinoma had a partial lobectomy. For those patients with follicular carcinoma, three had a lobectomy, one had a lobectomy plus radical neck dissection, and another had a total thyroidectomy plus radical neck dissection. Both patients with medullary carcinoma had a total thyroidectomy, and one, in addition, had a neck tissue biopsy. One patient with Hurthle cell carcinoma underwent a lobectomy plus radical neck dissection, while the other had a partial lobectomy. Only an open biopsy was performed on the patient with small cell carcinoma. The patient with sclerosing carcinoma underwent a lobectomy. The three patients with anaplastic carcinoma received one of the following: biopsy, partial lobectomy or total thyroidectomy.

TABLE II

OPERATIVE PROCEDURES	CASES
Lobectomy	72
Lobectomy Plus Portial Controlaterol Lobectomy	23
Partial Lobectomy	9
Open Biopsy	6
Excision of Isthmus	4
Totol Thyroidectomy	4
Total Thyroidectomy Plus Radicol Neck Dissection	4
Lobectomy Plus Radicol Neck Dissection	3
Total Thyroidectomy Plus Modified Neck Dissection	3
Cystectomy	2
Lobectomy Plus Modified Neck Dissection	2
Excision of Pyramidal Lobe	1
Total Thyroidectomy Plus Bilateral Neck Dissection	1
TOTAL	134

Fifty-four of the patients were placed on post-operative therapy consisting of thyroid extract or substitute for the purpose of thyroid replacement or to reduce the TSH titer, thereby hoping to reduce the degree of stimulation to the remaining thyroid tissue. Other types of post-operative therapy are included in Table III. Nineteen of the 25 patients with carcinoma were placed on thyroid extract after surgery. Four patients received post-operative irradiation. External radiation was used on the patient with small cell carcinoma until a lung metastasis was noticed. One patient with anaplastic carcinoma received external irradiation for palliation. Two patients received I^{131}, one patient having a follicular carcinoma and the other anaplastic carcinoma.

TABLE III

OTHER POST-OPERATIVE THERAPY	
Calcium Gluconote	7 cases
Vitomin D	5
Post-Operative Irradiation	3
Calcium Lactate	2
I^{131}	2
5 FU	1
PTU	1
Stilbesterol	1

There were 18 different histologic diagnoses made from the surgical specimens. This can best be shown by examining Table IV. Specimens with carcinoma were divided into eight different histologic types.

Morbidity and Mortality

Table V lists the various surgical morbidities encountered during thyroid surgery. There was no surgical morbidity with open biopsy, lobectomy or partial lobectomy. With total thyroidectomy one patient had hypocalcemia, another had hoarseness and two others were without complications. Only one patient with a lobectomy plus radical neck dissection had a benign post-operative course. One patient had hypocalcemia in addition to water intoxication. One suffered a laceration of the esophagus, while another had Horner's syndrome, hoarseness and drooping of one side of the mouth. The one patient who had a total thyroidectomy plus bilateral radical neck had a post-operative tracheo-esophageal fistula. Two patients had hypocalcemia following a total thyroidectomy plus modified radical neck dissection. One of these patients in addition had the vagus nerve on one side sectioned. Of the

TABLE IV

HISTOLOGIC TYPE		
Adenomatous Goiter	39	cases
Follicular Adenomo	38	
Colloid Nodule	15	
Popillory Corcinoma	10	*
Fetol Adenoma	6	
Follicular Corcinomo	5	*
Hurthle Cell Adenoma	4	
Undifferentiated Corcinoma	3	*
Colloid Cyst	3	
Hemmorrhagic Cyst	3	
Hurthle Cell Carcinoma	2	*
Follicular Cyst	2	
Severe Chronic Thyroiditis	2	
Hashimoto Strumo	2	
Medullary Corcinoma	2	*
Mixed Follicular and Papillary Carcinoma	1	*
Sclerosing Carcinomo	1	*
Small Cell Carcinoma	1	*

**Patients with carcinoma*

two patients who underwent total thyroidectomy plus radical neck dissection, one had no complications while the other's post-operative course was complicated by a chyle fistula and infections of the skin flap.

Six patients with carcinoma have died. One patient with anaplastic carcinoma died after readmission due to metastases. The other two patients with this type of carcinoma died prior to their follow up visit. The patient with small cell carcinoma died in the hospital due to a suspected pulmonary embolism. One of the patients with medullary carcinoma died of cardiac arrest while in the hospital. Another patient, 63 years old with papillary carcinoma, died in the hospital of pneumonia.

Natural History and Follow Up

For those patients who returned, the mean duration of follow up was 11.8 months. The longest follow up was six years. Ninety-four patients had no evidence of thyroid disease at the time of their last follow up. A complete listing of the patients status at their last follow up visit is shown in Table VI.

Nine of the patients with carcinoma are still being seen in the outpatient clinics. Six of these patients had papillary carcinoma, and their duration of follow up ranges from eight to 65 months. Two patients had follicular carcinoma and have been followed for 73 months and 84 months. A patient with medullary carcinoma has been followed for 24 months. None of these patients had evidence of recurrent thyroid carcinoma at the time of their last visit. One patient never returned for a follow up visit, and another was discharged to the care of his local physician. One patient with follicular carcinoma was discharged from the clinic with no evidence of disease after follow up visits over a 39 month period. Six patients failed to return after follow up visits ranging from two to 38 months. None of these patients had evidence of disease at the time of their last visit.

TABLE V

SURGICAL MORBIDITY

Hypocalcemia	5 cases
Hoarseness	4
Hypoparathyroidism	3
Pulmonary Congestion	3
Flap Infection	2
Hematoma	2
Chronic Aspiration	1
Chyle Fistula	1
Horner's Syndrome	1
Laceration of Esophagus	1
Pain in Shoulder and Neck	1
Recurrent Laryngeal Nerve Divided	1
Respiratory Difficulty Secondary to Edema	1
Tracheo-Esophagus Fistula	1
Tracheal Obstruction	1
Vagus Nerve Divided	1
Water Intoxication	1
TOTAL	30

TABLE VI

CONDITION AT TIME OF LAST FOLLOW UP

No Evidence of Disease	94 cases
Thyroid Remnant Enlargement	4
Cord Paralysis	2
Shoulder Pain	2
Hoarseness	1
Metastasis of Lung	1
Palpable Neck Nodes	1
Radiolucencies in Mandible	1
Stenosis of Esophagus	1

Discussion

Out of the 133 patients, 25 had thyroid carcinoma. Thus 18.8 per cent of the thyroid nodules were carcinoma. Seventeen women out of 117 had carcinoma in this series, for an incidence of 14.5 per cent. Eight men out of 16 had thyroid carcinoma. This important finding shows 50 per cent of the male sex with a thyroid nodule to have carcinoma. This figure is high when compared to the female sex incidence of 14.5 per cent. With thyroid carcinoma being present in one-half of the men having a thyroid nodule, haste should be taken to make a definitive diagnosis of all thyroid nodules. A poorer prognosis has also been indicated for those men with thyroid carcinoma[1]. The reported incidence of thyroid carcinoma varies from five to 20 per cent depending on the series[1, 2, 3, 4].

Of the 66 patients with "cold" nodules, 13 had carcinoma. Two of 20 patients with "warm" nodules had carcinoma. One of six patients with "hot" nodules was found to have carcinoma. Thus, this series demonstrates that 20 per cent of "cold" nodules are carcinoma, 10 per cent of "warm" nodules are carcinoma, and 12 per cent of "hot" nodules are carcinoma. With the differences of these results being as close as they are, one cannot depend on the scan to rule out thyroid carcinoma.

Thyroid nodules containing carcinoma varied in size from 1 by 1 cm. to 10 by 10 cm. This was the same range for all nodules in the

series. With this in mind, one cannot depend on the size of the nodule to indicate the presence of carcinoma since all sizes must be suspected.

Again the significance of irradiation to the head and neck region and resultant thyroid carcinoma is pointed out. Both patients in this series who received irradiation to the neck region had carcinoma. A series has been reported relating the characteristics of thyroid carcinoma after external irradiation to the head and neck[5].

Two patients were found to have thyroid carcinoma from metastatic lesions. This is much lower than one series where 28 per cent of the cases were diagnosed from a metastatic lesion when the thyroid gland was normal on physical examination[4].

The two cases with medullary carcinoma were family related. This is not an unusual finding and is further developed in other series[6, 7].

Hypocalcemia and hoarseness were the most common surgical morbidities. In another series, permanent tetany following total thyroidectomy was reported to occur in 11.4 per cent of the cases[1].

Patients with anaplastic carcinoma composed 12 per cent of those cases with carcinoma. This is somewhat lower than other series[4]. One patient had a sudden onset of his disease when the nodule reached its maximum size within a 24-hour period. The period from onset to surgery was five weeks. The other two patients had goiters for 10 and 15 years at which time there was a rapid increase in the size of the thyroid mass. In one patient, the long standing goiter received therapy in 1956 at which time carcinoma was found. Lung metastases were discovered the following year. At this medical center in 1962, the remaining thyroid tissue was removed. During the first year following complete removal of the thyroid tissue, the patient received I^{131}.

This series points out the significance of clinically palpable, cervical nodes. Of the 17 patients with palpable nodes, 13 had carcinoma in this series. Thyroid nodules occurring along with palpable cervical nodes should suggest thyroid carcinoma necessitating immediate definitive diagnosis.

Even though thyroid carcinoma is far down the list of occurrence of cancer, the incidence is high enough that almost all physicans will be confronted with the diagnosis and treatment of this disease. Careful palpation of the thyroid gland on all physical examinations can turn up early thyroid cancer. In one series over 50 per cent of thyroid carcinomas were discovered by the physician[4]. Even though the series at UKMC showed the time from onset to definitive diagnosis to be much shorter for those patients with carcinoma than those with other thyroid disease, all thyroid nodules should be under suspicion since nearly 20 per cent are carcinoma. Once a physician discovers a thyroid nodule, definitive diagnosis should be the next step. This can only be done by means of a surgical procedure. Due to the variability in the characteristics of the different types of thyroid carcinoma, one cannot depend on history, physical examination or short course drug therapy to rule out carcinoma. Prognosis will mainly depend on the histologic type of the carcinoma and the age of onset. However, early removal should also improve the prognosis.

Since the natural history of papillary and follicular carcinoma generally shows a slow growth of the primary lesion, surgical therapy plays an important role in treatment. The debate relating to the correct surgical approach has been long and varied[8, 9, 10, 11]. Since carcinoma is present in many different forms, one surgical procedure for all cases cannot be dictated. For all nodules, the starting point of therapy should be a lobectomy of the involved side. Even though the reported incidence of carcinoma in the contralateral lobe is 30 per cent, the clinical incidence of overt cancer is only 3.1 per cent[12]. This low rate does not justify the high morbidity rate of total thyroidectomy. However, thyroidectomy is justified in follicular carcinoma when metastatic disease is present to obtain the greatest effect from subsequent I^{131} therapy.

Cervical node metastasis as determined by histologic means can range from 40 to 60 per cent of the cases. Knowing this, most surgeons still prefer to reserve neck dissection for those cases where cervical nodes are clinically palpable, and many of these surgeons prefer a modified neck dissection[11]. The latter alternative is probably the most reasonable approach in patients with clinically palpable nodes and in all cases of papillary type

(Continued on page 621)

Medical Priorities

Romeo S. Berardi, M.D.*

McDowell, Kentucky

A three and one-half year study of all admissions to a small community hospital in Appalachia has been completed in order to establish priorities as primary considerations for medical programs as well as for educational programs.

THE Appalachian area has received a good deal of attention in recent years regarding its medical needs. Although it is not realistic to speak of medical priorities when faced with a given patient, one must, however, have some conception of the frequency of various diseases encountered in an area in order to formulate meaningful programs. In this way program priorities can be established and progressively instituted until such time that all medical needs have been adequately satisfied.

The same would appear to hold true for programs concerning continuing medical education for the practicing physician. It is more feasible to primarily emphasize those disease states which are met with greater frequency in daily practice. Working from the more commonly encountered diseases up to the least frequent ones would set meaningful priorities in organizing and instituting medical educational programs.

With a firm belief in this premise, the following study was carried out in a 60-bed hospital located in the southeastern part of Kentucky (Floyd County). The data presented concern only hospitalized patients and in no way is meant to reflect the frequency of disease states as encountered in the ambulatory treatment of patients, as exemplified in a study of Martin County, Kentucky[1]. However, since they do concern major illnesses necessitating hospitalization, their importance can not be minimized. Furthermore, it is felt that the data are more or less representative of most of Appalachia, since there is no evidence to indicate the contrary.

The study involves all discharged patients during a three and one-half year period from July, 1966 through December, 1969. Classification of patients into disease categories was coded according to the Hospital adaptation of the International Classification of Disease for Analysis (H-ICDA). The final discharge diagnosis explaining admission to the hospital was used to categorize and properly code the patient.

In Table II diseases are grouped according to systems and ranked accordingly. This enables one to focus his attention on the frequency of interrelated disease entities.

Discussion

Disease ranking is obviously influenced by many factors such as type of population, age, occupation, climate, location, sanitation, etc. No attempt, however, was made to analyze the above data in this light. This provides substance for further study.

This study, however, does show where priorities rest and from it one should be able to better formulate and establish future medical programs, be they practical, educational, preventive or social. It clearly demonstrates in which areas educational programs should be primarily directed. It simply is not realistic to devote the greater part of any educational program to areas which rank low. This is not to say that low ranking categories have no importance and, therefore, should be forgotten but rather they should be allotted time in proportion to their importance and frequency. A re-examination of Table II indicates the general areas to which most of our educational programs should be addressing themselves.

It is not surprising that diseases of the respiratory system rank number one. This category accounted for 18.8 percent of the total corrected admissions (excluding births and maternity) during this three and one-half year period. The annual number of patients admitted with respiratory disease has remained

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TABLE I

PATIENT GROUP BY FINAL DIAGNOSIS EXPLAINING ADMISSION	JULY 1966 - DEC. 1969 NO. OF PATIENTS							TOTAL	RANK
Newborn	93	115	121	115	107	108	76	735	1
Pneumonia/Bronchitis	80	134	100	111	103	76	84	688	2
Normal Deliveries	75	86	90	91	73	78	54	547	3
Other Heart	48	47	47	58	68	79	73	420	4
Other Trauma	64	36	81	34	37	48	74	374	5
Symptoms	61	35	31	26	72	71	50	346	6
Genitourinary	44	42	35	26	37	53	52	289	7
Other GI	56	53	48	41	25	21	41	285	8
Female Genital	54	41	35	33	32	18	27	240	9
Peptic Ulcer	38	33	26	28	40	32	38	235	10
Vascular	26	39	31	26	31	29	38	220	11
Comp. Deliveries	22	34	28	17	35	30	23	199	12
Cholecystitis/Calculus	21	21	26	17	26	32	41	184	13
Acute URI	32	17	17	39	31	7	41	184	14
Musculoskeletal	30	27	26	15	22	24	26	170	15
Other Respiratory	23	22	16	17	50	22	16	166	16
Malignancies Neoplasms	10	19	27	25	28	34	16	159	17
Fractures	15	18	31	17	15	28	24	148	18
Skin	32	16	25	9	10	27	26	145	19
Infective	10	9	15	13	46	38	10	141	20
CNS Vascular	17	15	20	19	20	23	26	140	21
Adverse Effects	22	17	21	17	14	18	29	138	22
Eye & Ear	25	25	14	22	14	6	15	121	23
Hernia	15	10	24	24	18	20	9	120	24
Comp. Pregnancy	18	13	12	18	15	23	10	119	25
Other Neoplasms	31	19	22	12	7	9	13	113	26
Diabetes Mellitus	13	20	10	11	12	13	19	98	27
Acute Myocardial Infarction	9	11	16	15	15	15	9	90	28
Abortions	15	10	15	14	12	4	12	82	29
Mental	8	10	14	6	15	8	13	74	30
Hypertension	6	19	10	5	16	7	10	73	31
Hematologic	8	5	8	5	14	12	8	60	32
Hypertrophy of T & A	8	8	17	7	3	6	9	58	33
Other Endocrine	4	3	9	10	3	3	12	54	34
Nutritional Metabolic					3	7			
Special	8	1	5	3	7	12	12	48	35
Other Nervous System	9	5	5	6	6	12	3	46	36
Appendix	9	8	10	4	5	6	3	45	37
Other Upper GI	2	2	2	3	14	10	3	36	38
Dental	5	6	6	1	8	4	1	31	39
Congenital	6	2	3	4	1	6	1	23	40

TABLE I (continued)

PATIENT GROUP BY FINAL DIAGNOSIS EXPLAINING ADMISSION	JULY 1966—DEC. 1969 NO. OF PATIENTS							TOTAL	RANK
Breast	6	5	1		2	6	2	22	41
Diseases of Infancy	4	1	5	1		1	7	19	42
Comp. Puerperium	1	1			1	1	1	5	43
Grand Total	1083	1060	1115	975	1113	1087	1057	7490	
Total, Except Births	990	945	994	860	1006	979	981	6755	
Total, Except Births and Maternity	859	801	839	710	870	843	881	5810	

essentially the same. This is also true of most all other categories. Pulmonary disease is one of the major causes of death in our hospital[2].

Diseases of the cardiovascular system accounted for 10.3 per cent of the total corrected admissions and represent the leading cause of early and late deaths in our hospital[2].

With the unresolved issues concerning ambulance service, equipment and adequately trained personnel, one can readily understand the great community concern which has been voiced. Trauma still remains an important area for concern. It ranks fourth in this study and accounts for 10.1 per cent of the total corrected admissions. A question which we should all sincerely ask ourselves is: "Have we given or are we giving adequate priority to this area?"

An interesting category is that labeled "Symptoms" which accounted for 5.7 per cent of admissions. The H-ICDA defines this as "physical signs, symptoms and ill-defined conditions for which no diagnosis classifiable elsewhere is recorded". The undiagnosed chest pain, abdominal pain, convulsions of unknown cause, and the many other subdivisions outlined in H-ICDA give one an enormous field for continued study, instruction and programming.

The seven systemic categories listed in Table II account for 76.3 per cent of admissions. Does this not indicate their importance in any medical program purporting to meet community needs?

To our knowledge, this represents the first study of this nature emerging from a hospital located in Appalachia.

Data

The study includes a total of 7,490 patients discharged during this three and one-half year period; corrected to 6,755 patients when births are excluded and to 5,810 patients when births and maternity cases are excluded.

In Table I, disease categories are ranked according to frequency. Excluding newborns, the most frequently encountered systemic disease is respiratory with pneumonia and bronchitis leading the subdivision.

Conclusion

A three and one-half year study of all hospital admissions in a small community hospital was undertaken. Diseased entities were ranked according to frequency. It is felt that the data presented might play a very important role in formulating, organizing and instituting medical programs to meet community needs in Appalachia.

TABLE II

SYSTEM	TOTAL NO. OF PATIENTS	RANK
Respiratory	1096	1
Cardiovascular	803	2
GI Including Liver & Biliary Ducts	785	3
Musculoskeletal Including Trauma	692	4
Genitourinary	529	5
Neoplasms (Both Malignant & Benign)	272	6
CNS	260	7

References

1. Steinman, D. and Watson K.: Illness in Martin County, Kentucky. *Appal. Med.* 1, 4, April, 1969.

2. Berardi, R and Hall, M.: Deaths in a Small Community Hospital. *Journal of KMA.* Oct., 1969.

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Usoge of ony drug in women of childbeoring oge requires thot the potential benefits of the drug be weighed against its possible hazords to the mother ond fetus.

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 per cent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For *essential hypertension in adults* the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For *edema, ascites or effusions in adults* initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For *children* the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Dall, J. L. C.: Amer. Heart J. 70:572-574 (Oct.) 1965. **2.** Liddle, G. W.: Ann. New York Acad. Sci. 139:466-470 (Nov.) 1966. **3.** Gantt, C. L.: Diuretic Therapy, DM (Disease-A-Month), Chicago, Year Book Medical Publishers, Inc., 1967, pp. 1-31. **4.** Alexander, S.: Geriatrics 23:131-139 (Nov.) 1968. **5.** Stason, W. B., and others: Circulation 34:910-920 (Nov.) 1966. **6.** Lieberman, F. L., and Reynolds, T. B.: Gastroenterology 49:531-538 (Nov.) 1965.

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Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Adverse Reactions: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

Dosage and Administration: Adults: Two tablets, orally, four times per day, followed by liberal fluid intake. Older children reduce dosage in proportion to age and weight.

How Supplied: Bottles of 50, 500 and 1,000 tablets.

References: (1) Sand, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961: (3) Haas, J., and Kay, L.L.: Southwest. Med. 42:30-32, 1961: (4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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Responsibility of Membership†

Richard B. McElvein M.D.

Membership in an organization carries with it certain responsibilities, rights and privileges. In return the organization has similar responsibilities to its members. Thus, an interaction between the two results in an effective voice for social action.

There are many reasons for belonging to an organization. Membership may be necessary for an individual's livelihood. It may provide him a voice or mechanism in matters which concern him. Through an organization a person can contribute to general progress.

There are many organizations in existence and one can pick and choose those to which he wishes to belong. Before joining he should be familiar with the goals and purposes of the society and endorse the general aims of the society. He must accept the organization as it is and if changes are necessary work diligently as a member for them.

Support of a society by keeping one's self informed of society actions, attendance at meetings, accepting committee responsibilities and payment of dues, tariffs and honorariums are all necessary.

Information at the local medical level is derived from meeting notices, the monthly Bulletin, committee reports, debate at meetings and minutes of previous meetings. At the state level of organized medicine you are the recipient of a monthly Journal and interim mailings and have the option as well as the obligation to attend the annual state meeting. At the national level a steady flow of information is provided by a weekly Journal, a Newsletter, specialty journals and other publications. A large annual and several regional meetings are open to interested members.

Meeting attendance is paramount. It is only by regular attendance that a member can exercise his prerogatives of discussion and voting as well as to acquaint himself with the thoughts and ideas of others.

Committee assignments are essential. In a large organization it is impossible for the total assembly to debate in detail and embark on fact finding missions. A committee can more leisurely explore, in as much depth as necessary, a given topic and reduce the idea with arguments pro and con to a written report which then can be evaluated by the membership at large, questioned as necessary and a proper vote taken. Committee work is sometimes mundane but it is always germane. It may be laborious but it is sometimes glorious.

The prompt payment of dues, tariffs and other assessed monies is essential support of an organization since all need monies to operate and promote their goals and ideals.

The rights of membership have evolved under a system known as Parliamentary Law. Parliamentary law is an aggregation of procedures and ethics for working together in groups. It has its foundation in general law and statutes, charters granted by government, constitution and by-laws developed by a particular group and an adopted parliamentary authority.

The purpose of parliamentary law is to facilitate the transaction of business and to insure equal rights and privileges for all members. The philosophy of parliamentary law is constructive. It is not to be used to confuse, delay or otherwise impede the will of the majority.

A keystone of parliamentary law and indeed democracy is *The Majority Rules.* Until a vote or decision is made there should be free and open discussion by any and all. After a decision has been reached by due process, this becomes the decision of all members.

What are the rights of individual members, what responsibilities do they carry and what obligation does the organization have with regard to these rights?

A member can expect to receive proper notice of meetings and he has the responsibility to heed these and act accordingly. The society must insure that due notice is given; the meetings are held in an appropriate place and no responsible member is barred from participating. With particular reference to special called meetings the society must follow the procedure of by-laws to insure that all are notified in sufficient time and proper fashion. The member at such a meeting must confine his discussion to that business for which the meeting has been called and no other.

A member has the responsibility of presenting motions at the appropriate time for deliberation by the assembled. The society, in the person of the chair, must insure that each member has an opportunity to present motions, that such motions

†*Presidential Address, Fayette County Medical Society, January, 13, 1970.*

are in order of precedence and that motions are discussed fully and dispatched in accordance with the by-laws and parliamentary law.

A member has the right and responsibility to debate all issues on the floor. All discussion must be relevant. He has the right when called upon to present his thoughts and ideas in a logical straightforward fashion in a brief period of time to the assembled. In like fashion when others have the floor and are speaking to the point, they have the responsibility of remaining quiet and conducting themselves in a gentlemanly fashion so that members may hear the full discussion and vote intelligently. The chair has the privilege to call upon members of the assembly in turn for their expression of opinion and also has the responsibility of ensuring that all who wish to speak have equal opportunity.

Long dissertations, not to the point, boisterous conduct and vituperation have no place in an open forum. Personal insults are to be decried. Members who have invested their time to attend should not be subjected to blasphemous statements having little or no bearing on issues involved. A motion may be attacked vigorously but it is never permissable to attack the character or personality of one who has made a motion or debated. It is the motion, not the proposer, that is the subject of debate.

At all times the minority must be heard. The chair must recognize and members should heed the words of minority groups. The minority of today may become the majority of tomorrow.

Voting is basic to a member. This is his means and mechanism of expressing his final opinion on an issue. He may vote for or against, or may abstain, basing his decision on all factors which in his opinion have a bearing. A member also has the right to have his vote tallied correctly, and promptly to hear the result of the vote. The mechanics of voting must be carried out in a fair impartial manner insuring the majority rule.

Nomination is another membership responsibility. He may, generally with the nominee's acknowledgement, offer the name of any person eligible for an office. The nomination then must be accepted by the membership and voted upon in due fashion.

To hold office is both a responsibility and a privilege. Any qualified member may hold office provided he has been properly nominated and an accurate vote has been taken. To serve under other circumstances is foolhardy both for the officer and the organization. In accepting office he must conduct himself with fairness and decorum at all times. He must complete his duties as charged by the society or other officers. He must remind himself at all times of his role and responsibility to those who have placed their faith and trust in him by electing him to office.

Additionally a member has the right to inspect records of the organization including having available a current copy of the constitution and by-laws.

A member has both the right and responsibility to insist on rule enforcement and the proper application of parliamentry law by the officers. The society can not infringe on these basic rules of behavior and organization.

Any member whose conduct or behavior is considered less than desirable has a right to a fair hearing so that he may not live with a smirch on his record if that be the case.

And finally a member has the right to resign from an organization at any time and should do so if he is unable to live by the rules of the organization or feels that the purposes of his organization no longer meet his needs.

Organizational rights also exist. A group has certain authority under law, may change its goals and purposes, may establish eligibility requirements governing member admission, may delegate authority within legal limits to its officers, committees and employees, may select committee members and may suspend or remove them for valid cause. An organization must discipline or expel members in accordance with its laws, after fair hearing. It may also hold property, and defend or enter into litigation in its own name as incorporated.

A strong interrelationship perforce exists between members and their organization. All members should keep in mind the goals of their group, their responsibilities and their rights. An uninformed, uninterested membership results in a poor non-vital organization which may fall into the hands of unscrupulous persons who will use the society to its own ends and not abide by the general spirit of fairness, free discussion and majority rule. An interested and vocal membership insures that organizational goals will be attained and progress made.

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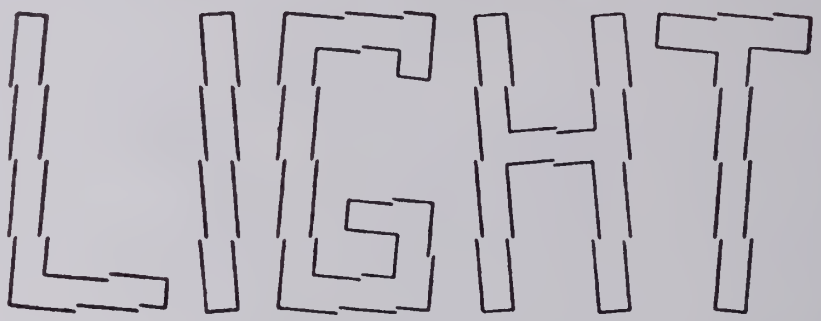
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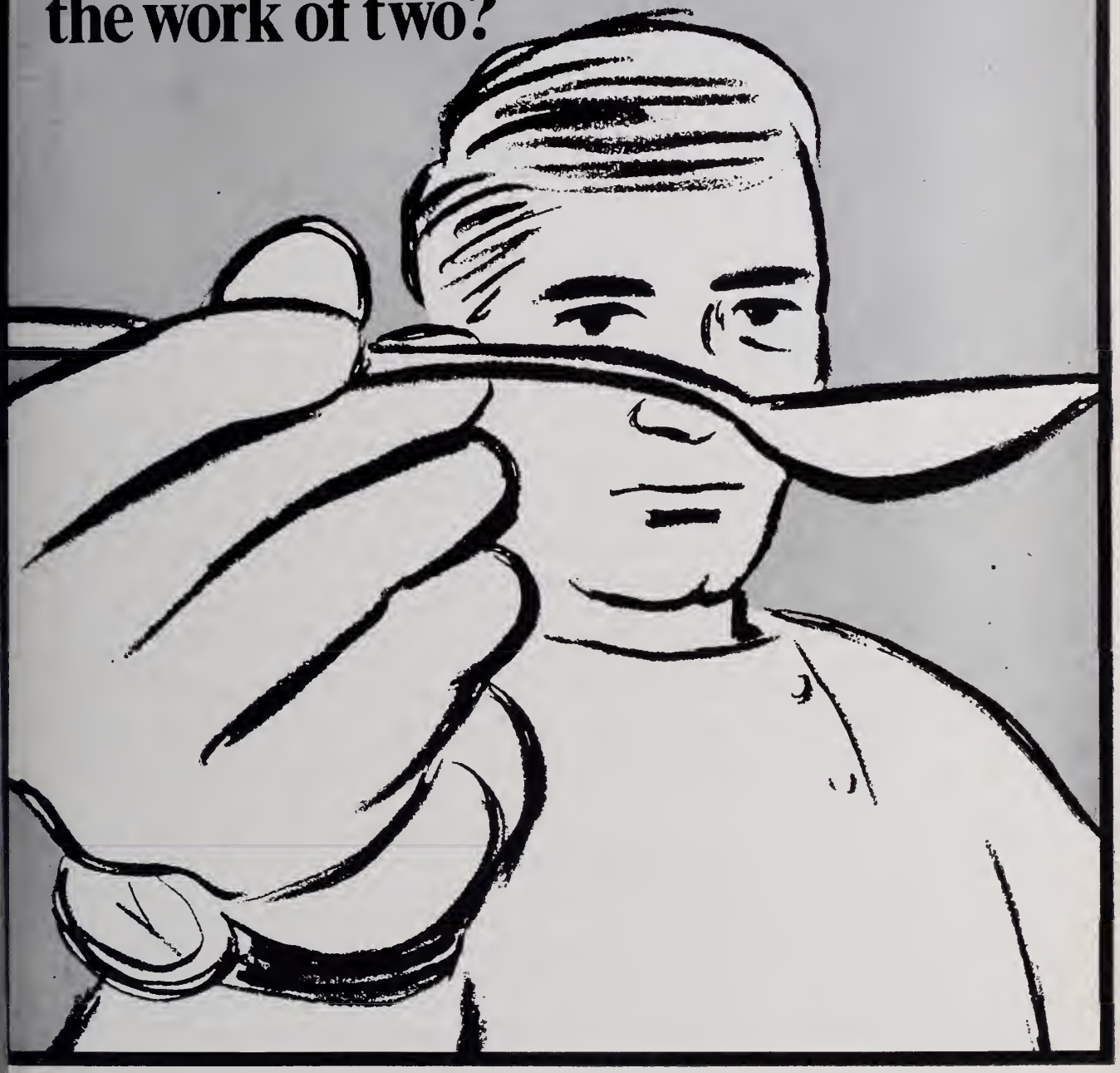


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IN APPRECIATION TO WALTER S. COE, M.D.

WHEREAS, Walter S. Coe, M.D., of Louisville, Kentucky served with untiring diligence as Book Review Editor of the *Journal of the Kentucky Medical Association* from 1958 until 1962, and

WHEREAS, he assumed the additional responsibility of serving as Assistant Editor of *The Journal* from 1962 until 1966, and

WHEREAS, in 1966, he assumed the demanding position of Editor of *The Journal* and served with high distinction in that position through September, 1970, and

WHEREAS, he has served *The Journal* and the Kentucky Medical Association with untiring efforts for the past twelve years, and

WHEREAS, he has brought to *The Journal* of KMA, the same high ethical and moral standards which he exhibits in every phase of his medical endeavors, and

WHEREAS, in addition to the great service rendered to KMA, he has served his County Medical Society with sincere and devoted efforts and has, in 1970, assumed the office of President of his Society, now, therefore be it

RESOLVED, that the Board of Trustees of the Kentucky Medical Association hereby expresses to Walter S. Coe, M.D. its sincere thanks and deep and lasting appreciation for the outstanding service he has performed for *The Journal* of KMA, for the Kentucky Medical Association, for his County Medical Society, and for his contribution to Continuing Medical Education, and be it further

RESOLVED, that this resolution become an official part of the proceedings of the Board of Trustees of the Kentucky Medical Association meeting at Louisville, Kentucky, August 6, 1970, and that a copy of this Resolution be tendered to Doctor Coe at a time and place deemed appropriate by the Board.

EDITORIALS

A Voice of Reason

For the past 12 years this Journal has been blessed with Walter Coe's presence on its editorial staff, first as Book Review Editor, then Assistant Editor, and, for the past four years, as Editor. For those of you throughout the state who have come to know and appreciate the tenor of Doctor Coe's writings, allow me to fill in for you a bit about the man himself.

In the midst of almost universal unrest and discord, both within and without medicine, Doctor Coe seems able to pursue his own calm and rational course without stridor or offense. In potentially heated situations his quiet voice and his smile of amusement (sometimes at himself as well as at the situation itself) persist, serving often to help cool tempers and facilitate proper solutions. As a former full-time medical academician, he retains a touch of the teacher in his makeup—an ability to see all sides of a problem, a reluctance to jump to conclusions, a facility, even under stress, for theoretical contemplation rather than gut-reaction. It's been my privilege to work with Doctor Coe in this journalistic field and others in the past few years, and it's been a constant pleasure for me to see him handle varying problems, from medical student activism to running a state medical journal (and that's a *real* problem!). If what I've said till now makes you feel Doctor Coe seems too quiet, too low-pressure to be a leader—think again about leadership and what it really is. Although he listens, he also thinks, develops his own ideas, and acts upon them. He has been President of the Kentucky Society of Internal Medicine, the Kentucky Heart Association, and is now President of the Jefferson County Medical Society, and has been most effective in each position.

And so, a personal salute to Walter S. Coe, retiring Editor of *The Journal of the Kentucky Medical Association*, on behalf of his appreciative co-workers. That we are not alone in our appreciation is documented in the resolution (opposite page) passed August 6, 1970, by the Board of Trustees of KMA.

Well done, Walter.

WALTER I. HUME, JR., M. D.

The Annual Meeting

THE Annual Meeting of the Kentucky Medical Association occurring in September is an event that is looked forward to by many Kentucky physicians and their wives. This is demonstrated by the fact that for a number of years a record percentage of Kentucky physicians attend their State Meeting.

The meeting this year promises to be a good one. The program offers a wide variety of interesting and worthwhile subjects. The Tuesday morning session is given to the diagnosis and management of emergencies. Psychiatric, urologic, obstetrical and vascular will be among the seven types of emergencies discussed by experienced physicians in each of the areas. Tuesday afternoon (September 22) eight specialty groups will present programs. Here again a great variety of important subjects will be discussed and those in attendance may move from one group to another as they wish. Wednesday morning the theme will be Cardio-Pulmonary Resuscitation. All aspects of this vital subject will be presented. On Wednesday afternoon following three papers given to the general session—the "Crackerbarrel Session" will be presented. This session has proven to be popular in the past and again is offering a wide variety of useful subjects. The following morning (Thursday, September 24) the two main general themes will be "Industrial Medicine" and "Tuberculosis". The afternoon will be occupied by the meetings of eight specialty groups.

A number of well-known, out-of-state physicians will be participating in the meeting this year. In addition to the scientific sessions the

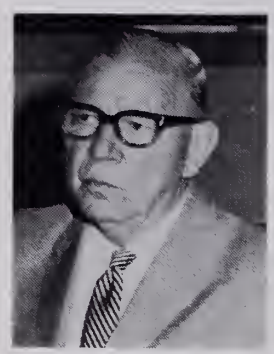
Women's Auxiliary will hold its Annual Convention. There will be two sessions of the KMA House of Delegates—at which, matters of importance to all Kentucky physicians will be discussed and voted upon. There will be meetings of University of Louisville Alumni and the annual KEMPAC Seminar. Some 90 scientific and technical exhibits are to be arranged.

In addition to all of this—you have the opportunity in September, in Louisville, to greet an old friend. This alone, should make the trip worthwhile.

WALTER S. COE, M.D.

Russell E. Teague, M.D.

A SEVERE illness in the early summer this year precipitated Doctor Teague's retirement as Commissioner of Health for Kentucky, a position he had held since 1956. It is appropriate that we record here an expression of deep appreciation felt by the physicians and the people of the state for the long and faithful service that he, a public servant, has rendered. Wherever I have met with Public Health officials, even in remote areas, the mention of him has elicited statements of respect and praise for his stature and achievements in his chosen field.



Doctor Teague is a native of Hopkins County. He received his Bachelor's degree from the University of Kentucky in 1925 and studied medicine at the University of Louisville where he graduated in 1929. He obtained the degree of Master of Public Health at Johns Hopkins University in 1933, later pursuing studies in epidemiology at the University of Michigan School of Public Health. He is a Diplomate of the American Board of Preventive Medicine and Public Health.

He practiced medicine for a period in Bardstown before becoming Director of the Wayne County Health Department in 1931. Thereafter he continued in County Health work until 1940 when he came to the State Department of Health as director of Venereal Disease Control and later of Tuberculosis Control until 1945 when he entered the U.S. Public Health service in New York. He was assistant director of Henry Phipps Institute in Philadelphia from 1946 to 1951 and Secretary of Health for Pennsylvania from 1951 to 1955 at which time he resigned in order to return to Kentucky.

During his extended period as Commissioner, the Health Department was moved from Louisville to Frankfort; there were renewed efforts at Venereal Disease and Tuberculosis Control; the personnel of the Department increased greatly and the facility was enlarged. The Medicaid program came into being and Kentucky was among the first states to activate it; Doctor Teague promoted its supervision by the Department of Health, keeping its control as largely as possible in physicians' hands, which, with all of its handicaps, has proven to be a good thing for the state. He prepared and promoted the statewide Polio Vaccination Program in 1963-64. In the past two years he has inaugurated the program of Vaccination against German Measles. These activities have been of inestimable value to the health of our people.

He has taught public health on the faculties of Harvard University, University of Pennsylvania, University of Pittsburg, University of Louisville, and University of Kentucky, and has published many reports and papers in this specialty. A member of a great number of organizations and committees of national scope, he was chairman of the Section on Preventive Medicine of AMA, 1964-65, and president, Association of State and Territorial Health Officers, 1968. He has received five Distinguished Service Awards, the latest being the University of Louisville Distinguished Hospital Alumnus Award in 1969. On May 12, 1969, the University of Kentucky conferred upon him the honorary degree of Doctor of Law.

Doctor Teague has been secretary of the State Board of Health since 1956. The Legislative Research Council, which was formed following the 1968 session of the Legislature, recommended reorganization and enlargement

(Continued on page 621)



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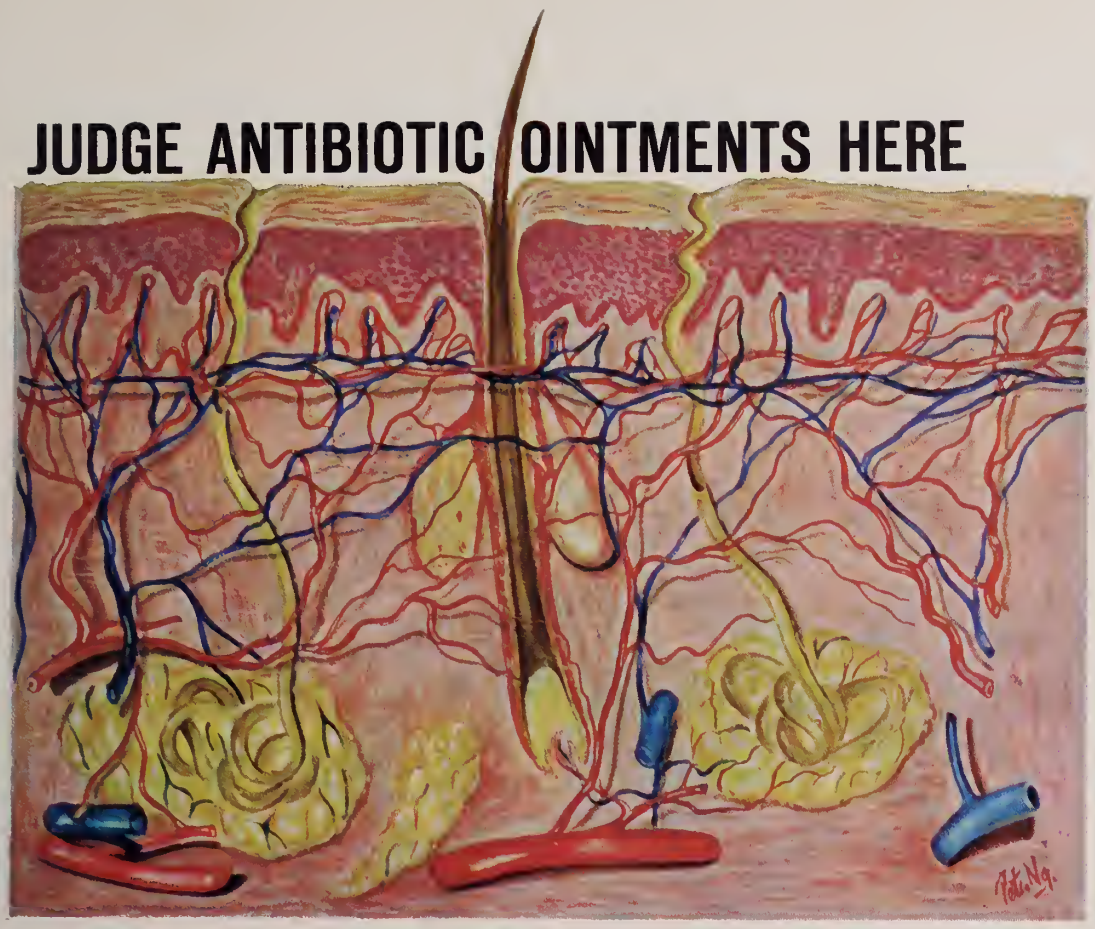
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SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

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WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

WILLIAM P. POYTHRESS & CO., INC.
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ORGANIZATION SECTION

KMA Annual Meeting To Offer Many Special Features

Scientific sessions featuring Kentucky physicians and prominent guest speakers from throughout the country will be an important highlight of the 1970 Annual Meeting September 22-24 in Louisville.

Presentations will deal with such topics as "Emergencies," "Cardio-Pulmonary Resuscitation," "Industrial Medicine" and "Tuberculosis." A Cracker-barrel Session on Wednesday afternoon will consist of informal discussions of many timely medical topics.

The author of the book *At Your Own Risk*, Ralph Lee Smith, will be the guest speaker at the President's Luncheon on Wednesday, September 23, at 11:50. Held in the Flag Room of the Kentucky Hotel, the Luncheon will also feature the presentation of KMA top awards.

An outstanding variety of technical and scientific exhibits will be on display during the three-day session at Convention Center. Members will have an opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

Other highlights of this year's Annual Meeting include two sessions of the KMA House of Delegates, an Orientation program for new KMA Members, the 48th Annual Convention of the Women's Auxiliary to KMA, the annual KEMPAC seminar, meeting of the 16 specialty group and alumni reunions of the University of Louisville School of Medicine.

Board Appoints Dr. Hume Editor; Fills Other Journal Positions

Walter I. Hume, Jr., M.D., Louisville, was elected editor of *The Journal of the Kentucky Medical Association* by the Board of Trustees at its August 6 meeting. Doctor Hume succeeds Walter S. Coe, M.D., Louisville, whose resignation was accepted by the Board after having completed two consecutive terms as *Journal* editor. Doctor Coe's service as editor is outlined in an editorial appearing in this *Journal* on page 601.



Doctor Hume



Doctor Asman



Doctor Overstreet



Doctor Smith

Doctor Hume has served as assistant editor of *The Journal* since 1966. A 1949 graduate of Harvard Medical School, he is a clinical assistant professor of surgery at the University of Louisville. Doctor Hume is the immediate past president of the Jefferson County Medical Society and is chairman of the KMA Committee on Medical Education.

Elected to the position of associate editor was Henry B. Asman, M.D., Louisville, immediate past president of KMA. A 1936 graduate of the University of Louisville School of Medicine, Doctor Asman has served as the Association's vice-president and secretary in previous years. This past year he has been active as chairman of the KMA Ad Hoc Committee on Finance.

The Board also named Sam A. Overstreet, M.D., Louisville, to serve as assistant editor. A former *Journal* editor for eight years, Doctor Overstreet has been the associate editor since 1966. Also a past KMA president, Doctor Overstreet is an active member of the Southern Medical Association and the American College of Surgeons.

Charles C. Smith, Jr., M.D., Louisville, will continue to serve as scientific editor, a position he has held since 1967. Doctor Smith graduated from the University of Louisville School of Medicine in 1955 and has practiced internal medicine in Louisville since 1962.

Drs. Willard, Bosomworth Named To New Posts At U.K.

William R. Willard, M.D. and Peter P. Bosomworth, M.D., both of Lexington, have been named to new positions at the University of Kentucky. Doctor Willard has been appointed to a newly created post as special assistant for health affairs to University president Otis A. Singletary. Named to succeed Doctor Willard, Doctor Bosomworth will serve as vice-president in charge of the Medical Center. Both will assume their new duties on October 1.

After 14 years as vice-president of the Medical Center, Doctor Willard will work closely with the

U.K. president in all health fields—medicine, dentistry, nursing, pharmacy and the allied health professions.

A graduate of Yale Medical School, Doctor Willard was formerly dean of the Syracuse College of Medicine. He is credited with the initial organization and staffing of the multi-million dollar medical center in Lexington.

Doctor Bosomworth, who has been a professor and chairman of the department of anesthesiology at the Medical Center since 1962, has also been associate dean for clinical affairs in the University of Kentucky College of Medicine.

A 1955 graduate of the University of Cincinnati School of Medicine, Doctor Bosomworth was the 1969 recipient of the KMA Faculty Scientific Achievement Award which is presented annually during the KMA Annual Meeting to a faculty member of each of the two medical schools in the state.

Action Taken on 201 Items At AMA Annual Session

The AMA House of Delegates considered a record volume of business during the 1970 Annual Convention of the Association held June 21-25 in Chicago. Two hundred and one items of business were considered, including 61 reports and 140 resolutions.

Wesley W. Hall, M.D., of Reno, Nev., was chosen president-elect. KMA's candidate Robert C. Long, M.D., Louisville, lost his president-elect bid by a close vote on the third ballot. Doctor Hall will become the 126th AMA president at the Annual Convention, June, 1971, in Atlantic City.

In other actions of the House, a much-debated statement on abortion was passed and membership dues were raised to $110 to help finance needed programs.

In addition to business actions, the delegates to the House and other members of the Association heard outgoing President Gerald D. Dorman, M.D., present a challenge to attain and maintain a specific minimum health standard of "a healthy child and a healthy mother." AMA President Walter C. Bornemeier, M.D., in his inaugural address, called for greater emphasis on patient care through an overhaul of medical education and training.

AMA Judicial Council Sponsors Congress on Medical Ethics

An investigation into the problems of medical ethics in the 1970's will be conducted during the Third National Congress on Medical Ethics in Chicago, September 19-20.

Sponsored by the Judicial Council of the American Medical Association, the biennial conference will be held at the Ambassador West Hotel and is open to physicians and to students of ethics.

A conference highlight will be a mock hearing before a simulated county medical society ethics committee. Acting as committee members will be Vincent Sarley, M.D., Chicago; B. G. Mitchell, M.D., Memphis; and John A. Naber, M.D., Southgate, Ky.

For further information write the Department of Medical Ethics, AMA, 535 North Dearborn, Chicago, Ill. 60610.

1970 Golf Tournament To Be Held Sept. 23 at Hurstbourne

Arrangements have been made to hold the 1970 Golf Tournament at Hurstbourne Country Club in Louisville on Wednesday, September 23. An annual event, the tournament is being held again this year during the KMA Annual Meeting. The country club will be open that day to KMA members entering the tournament, according to Donald Ware, M.D., secretary of the Golf Association.

Participants may tee off after 12:00 noon and may make up their own foursomes. KMA members desiring to play in this year's tournament must submit their fees and application forms prior to the registration deadline of September 21.

APPLICATION FORM
Golf Tournament

Please complete and return immediately to: Donald L. Ware, M.D.
750 Medical Towers South
Louisville, Kentucky 40202

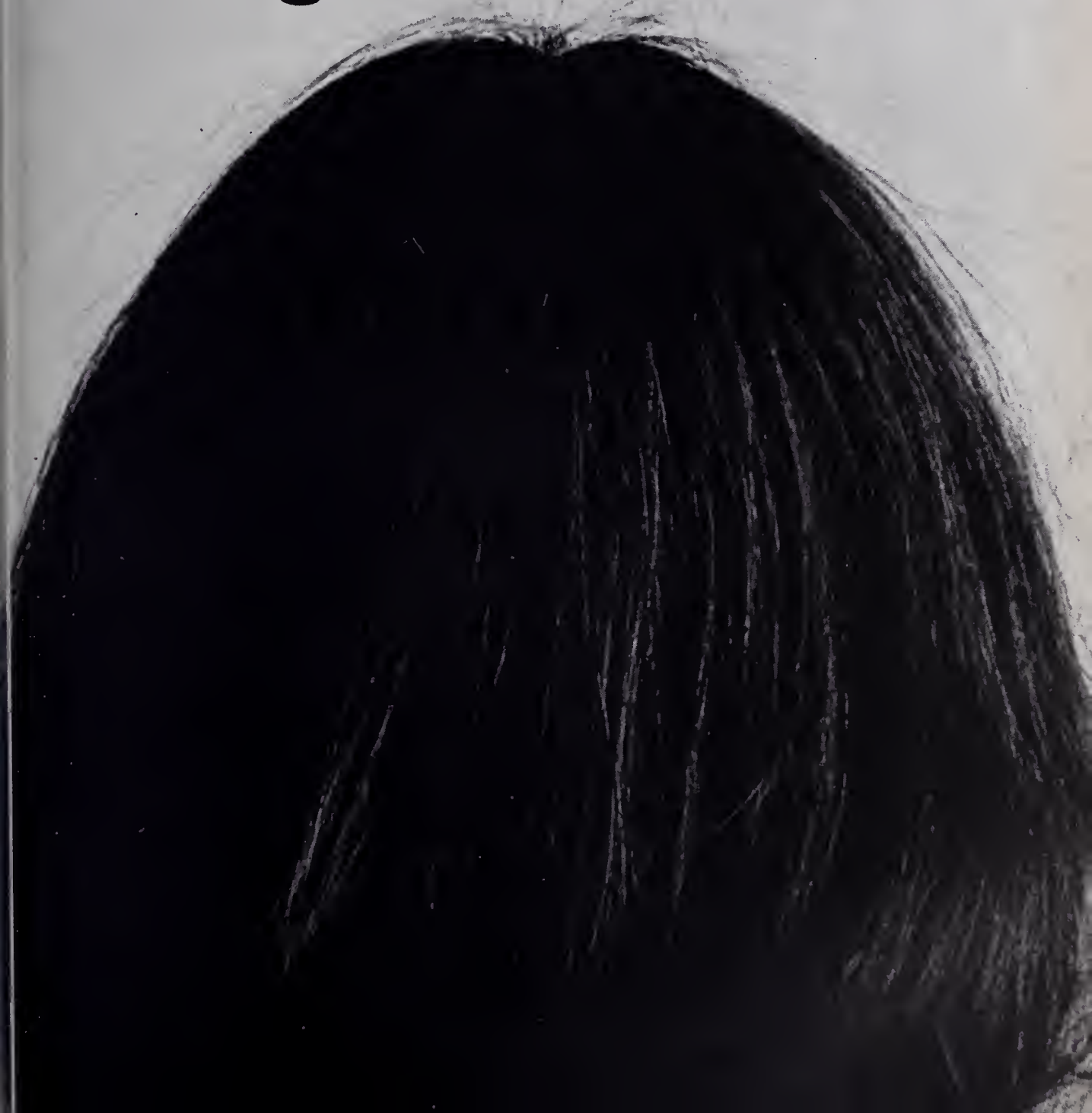
Name .....

Address ..... (Town) .....

Amount enclosed ($10 fee) ..... ($8—green fee; $2—prizes)

TOURNAMENT WILL BE HELD WEDNESDAY, SEPTEMBER 23

I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® (strip pack), Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)
Wyeth Laboratories
Philadelphia, Pa.

Photo professionally posed.



Medical Groups Plan Meetings During KMA Annual Session

Several miscellaneous meetings have been planned before and during the KMA Annual Session. The time, date and place of meetings scheduled at press time are listed below.

Sunday, September 20

12:30 p.m. KMA Board of Trustees, Luncheon meeting, Parlor A, Kentucky Hotel

Monday, September 21

8:00 a.m. KMA Awards Committee, Breakfast, Room 203, Kentucky Hotel

8:30 a.m. Orientation Program, New KMA Members, Mirror Room, Kentucky Hotel

9:00 a.m. KMA House of Delegates Meeting, Terrace Room, Kentucky Hotel

12:30 p.m. Reference Committee Chairmen, Luncheon, Room 317, Kentucky Hotel

2:00 p.m. Six Reference Committee meetings, Parlors A, B, C & D and Rooms 203 and 204, Kentucky Hotel

6:00 p.m. KEMPAC Reception, (Sponsored by the University of Louisville Medical School Alumni Association), Seminar, and Banquet, Flag Room, Kentucky Hotel

Tuesday, September 22

7:30 a.m. Executive Committee, Kentucky Obstetrical and Gynecologic Society, Breakfast, Room 205, Kentucky Hotel

11:30 a.m. Executive Committee, Kentucky Chapter, American Academy of Pediatrics, Luncheon meeting, Room 317, Kentucky Hotel

12:00 noon KMA Board of Trustees, Luncheon meeting, Parlor A, Kentucky Hotel

5:30-7:15 p.m. KMA—Woman's Auxiliary Reception, Mirror Room, Kentucky Hotel

5:30 p.m. Kentucky Psychiatric Association, Social Hour and Dinner, Parlors B & C, Kentucky Hotel

5:30 p.m. Kentucky Society of Anesthesiologists, Social Hour, Ship Room, Kentucky Hotel

6:00 p.m. Kentucky Urological Society, Social Hour and Dinner, Oak Room, Sheraton Hotel

6:30 p.m. University of Louisville School of Medicine Class of 1935 Reunion, Social Hour and Dinner, Big Springs Country Club

6:30 p.m. Kentucky Chapter, American College of Chest Physicians and Kentucky Thoracic Society, Social Hour and Dinner, Stouffer's Inn

6:30 p.m. Kentucky Chapter, American Academy of Pediatrics, Social Hour and Dinner, Executive Inn

Wednesday, September 23

7:30 a.m. Kentucky Society for the Prevention of Blindness Medical Advisory Committee, Breakfast meeting, Parlor B, Kentucky Hotel

7:30 a.m. Kentucky Academy of General Practice, Insurance Commission, Breakfast meeting, Room 204, Kentucky Hotel

9:00 a.m. State Board of Health meeting, Room 317, Kentucky Hotel

11:50 a.m. President's Luncheon, Flag Room, Kentucky Hotel

5:00 p.m. Board of Trustees meeting, Parlor B, Kentucky Hotel

5:45 p.m. Board of Trustees, Dinner, Parlor A, Kentucky Hotel

6:00 p.m. House of Delegates Subscription Dinner, Terrace Room, Kentucky Hotel

7:00 p.m. House of Delegates, Terrace Room, Kentucky Hotel

Thursday, September 24

7:00 a.m. MEA Liaison Committee, Breakfast, Room 203, Kentucky Hotel

7:30 a.m. TB Panel, Breakfast, Room 202, Kentucky Hotel

11:00 a.m. Kentucky Chapter, American College of Surgeons, Luncheon meeting, Parlor B, Kentucky Hotel

12:00 noon KMA Board of Trustees, Luncheon, Parlor A, Kentucky Hotel

12:00 noon Kentucky Association of Public Health Physicians, Luncheon meeting, Room 317, Kentucky Hotel

12:00 noon Kentucky Society of Pathologists, Lunch-Luncheon, Parlor C, Kentucky Hotel

12:00 noon Kentucky EEN&T Society, President's Luncheon, The Old House

12:15 p.m. Kentucky Industrial Medical Association, Luncheon meeting, Suite 1510, Kentucky Hotel

6:30 p.m. Kentucky EEN&T, Social Hour and Dinner, Executive Inn

Ky. Pharmacists Elect Rolfsen; Install Taylor As President

Richard H. Rolfsen, R. Ph., Fort Wright, was chosen as president-elect of the Kentucky Pharmaceutical Association, at its 93rd Annual Convention, held July 19-22 in Covington. Rolfsen will succeed Joe D. Taylor, R. Ph., Glasgow, who was installed as president.



Mr. Rolfsen

A 1952 graduate of the University of Cincinnati College of Pharmacy, Rolfsen is a former vice-president of the Kentucky Pharmaceutical Association and has served on the Association's Board of Directors since 1964.

Rolfsen is a past president and chairman of the Board of the Northern Kentucky Pharmacists Association. He is also a member of the Kentucky Council on Pharmaceutical Education.

Menrium® treats the menopausal symptoms that bother him most.



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Nutley, New Jersey 07110

His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through *her* menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

AMA Annual Meeting Attended by 96 Kentucky Physicians

Ninety-six physicians represented Kentucky at the 119th Annual Convention of the American Medical Association June 21-25 in Chicago. The AMA registration records show that the following Kentucky physicians attended the Convention:

LOUISVILLE

John D. Allen, Jr., M.D.
John W. Ambach, M.D.
W. Austin Bloch, M.D.
Warren W. Borsch, M.D.
Charles G. Bryant, M.D.
Norman K. Cohen, M.D.
David M. Cox, M.D.
M. R. Cronen, M.D.
James W. Davis, M.D.
Elbert L. Dennis, M.D.
Lewis Fine, M.D.
James R. Flautt, Jr., M.D.
Hoyt D. Gardner, M.D.
J. Thomas Giannini, M.D.
Norman Glazer, M.D.
Joseph L. Goldstein, M.D.
Cecil L. Grumbles, M.D.
Raymone Heitz, M.D.
David L. Hill, M.D.
William K. Keller, M.D.
Nathan Levene, M.D.
Robert C. Long, M.D.
Marvin A. Lucas, M.D.
Robert W. Lykins, M.D.
Gaston N. Maya, M.D.
Maurice Nataro, M.D.
James E. Parker, M.D.
Aaron Rabb, M.D.
Frank Radmacher, Jr., M.D.
J. A. W. Richardson, M.D.
W. Fielding Rubel, M.D.
William T. Rumage Jr., M.D.
Joseph E. Sadtler, M.D.
Napoleon A. Saliba, M.D.
S. Randolph Scheen, M.D.
William W. Spalding, M.D.
Frank M. Stites, M.D.
Carroll L. Witten, M.D.
William E. Yancey, M.D.

LEXINGTON

James W. Bard, M.D.
Lester R. Bryant, M.D.
Louis D. Dubilier, M.D.
Joseph Hamburg, M.D.
David A. Hull, M.D.
V. A. Jackson, M.D.
Coleman C. Johnston, M.D.
Paul Mandelstam, M.D.
Edward H. Ray, Jr., M.D.
Lloyd F. Redick, M.D.
David B. Stevens, M.D.
Wellington B. Stewart, M.D.
Borys Surawicz, M.D.
Sumiko Tsukamura, M.D.
William R. Willard, M.D.
Jonathan D. Wirtschafter, M.D.

OTHER CITIES

John C. Bishop, M.D., Fort Knox
Chester M. Blanton, M.D., Paducah
George F. Brockman III, M.D., Greenville
William H. Bryant, M.D., Glasgow
James C. Cantrill, M.D., Georgetown
Eugene A. Castle, M.D., Madisonville
Walter L. Cawood, M.D., Ashland
Phyllis D. Corbitt, M.D., Wilmore
Terry L. Davis, M.D., Bowling Green
Anthony Di Flumen, M.D., Fort Knox
Eulius S. Downs, M.D., Middlesboro
David D. Drye, M.D., Bradfordsville
Elizabeth P. Fleming, M.D., Paris
William C. Gardner, M.D., Madisonville
William W. Hall, M.D., Owensboro
Daryl P. Harvey, M.D., Glasgow
Lee C. Hess, M.D., Florence
Anne H. Hopwood, M.D., Owensboro
Charles C. Kissinger, M.D., Henderson
Onofre B. Llaneza, M.D., Fort Campbell
Robert T. Longshore, M.D., Covington
Merle M. Mahr, M.D., Madisonville
William I. Mariencheck, M.D., Fort Knox
John S. McIntyre, M.D., Fort Campbell
Earl P. Oliver, M.D., Scottsville
Martin B. Popp, M.D., Fort Thomas
John C. Quertermous, M.D., Murray
Fred C. Rainey, M.D., Elizabethtown
Charles C. Rutledge, M.D., Hazard
William M. Savage, M.D., Maysville
Frank K. Sewell, M.D., Mount Sterling
Harold B. Simms, M.D., Springfield
Dixie Snider, M.D., Springfield
John J. Sonne, M.D., Bardstown
Donald M. Stevens, M.D., Highland Heights
William Lee Tyler, M.D., Owensboro
Frank Vinicor, M.D., Fort Knox
L. H. Wagers, M.D., Hazard
Paul M. Walstad, M.D., Harlan
Ira F. Wheeler, M.D., Oneida
Frank L. Yarbrough, M.D., Owensboro

Free TB Tests To Be Available At KMA Annual Meeting

Mantoux tuberculin tests will be available to physicians and visitors to the KMA Annual Meeting, September 22, 23 and 24, at the Convention Center in Louisville.

The tests are to help promote the use of prophylactic drugs among persons with large reactions as a means of eradicating tuberculosis, according to Richard B. McElvein, M.D., Lexington, vice-president of the Kentucky TB and Respiratory Disease Association.

The free tests, sponsored by the Kentucky Thoracic Society and the State Department of Health's Division of Tuberculosis, will be given adjacent to an exhibit on tuberculosis which will be situated in the Scientific Exhibit Hall. The booth will be staffed by the Health Department's TB project nurses.

Billing Practice Rules Set

The Judicial Council of the Kentucky Medical Association at a recent meeting decided to note in *The Journal* and the *Communicator* the following ruling on billing practices made by the Council: (1) that a physician who is acting as a "collecting agent" for a hospital may not bill the third party for an anesthetic administered by a nurse unless he has personal knowledge of it *or* the operating surgeon has signed *either* the anesthesia report or the anesthesia block on the claim form and (2) that under AMA Res. 71, physicians who use outside laboratories must, when billing the patient, show the name of the laboratory and the amount of the laboratory's charge to the physician and state *separately* any additional charge which the physician makes in connection with the laboratory service.

Mrs. Betty Hall Joins KMA Journal Staff

Robert G. Cox, managing editor of *The Journal* of KMA, has announced that Mrs. Betty Hall, Louisville, has joined *The Journal* staff as assistant managing editor.

Mrs. Hall, a 1952 graduate of the University of Louisville, will replace Mrs. Diane Maxey, who has held this position since July, 1969.

An English major in college, Mrs. Hall served as editor-in-chief, news editor and feature writer of the *Cardinal*, the University of Louisville newspaper, while she attended there. She has since done journalism work for the Kentucky Rural Electric Cooperative Corporation.



Drip stopped, Congestion cleared

For upper respiratory allergies and infections, up to 12 hours clear breathing on one tablet. Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely.

INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, rhinitis, conjunctivitis, and otitis. CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. DOSAGE: 1 Extentab morning and evening. SUPPLIED: Bottles of 100 and 500.

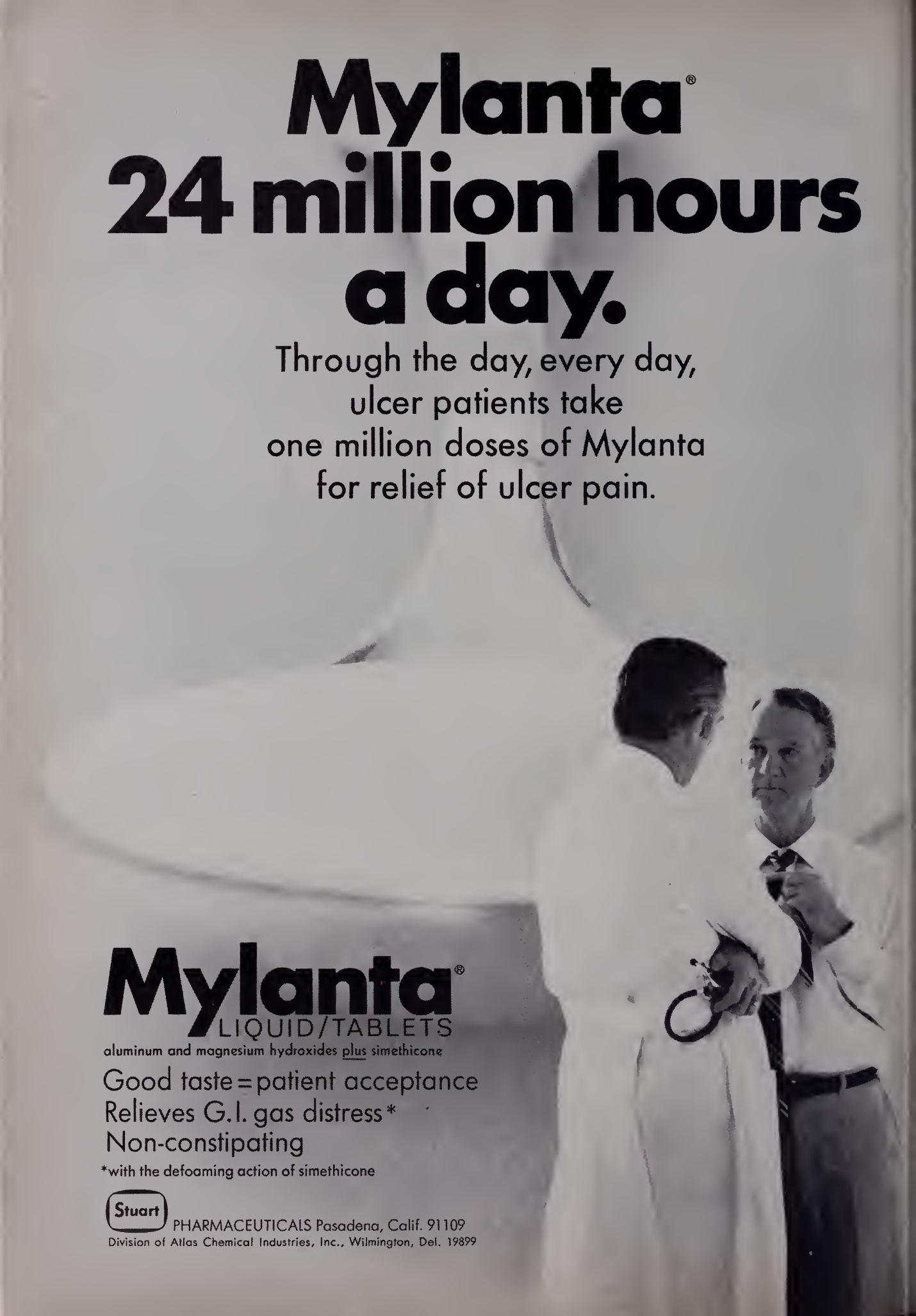
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24 million hours a day.

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for relief of ulcer pain.



Mylanta®
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Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

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Physician-Population Ratio of Kentucky Counties Noted for 1970

The Rural Kentucky Medical Scholarship Fund, in determining the "critical" and "semi-critical" counties of Kentucky, in terms of physician-population ratio, have used the preliminary 1970 census figures in drawing the following statistics.

In the United States the physician-population ratio is one physician to every 630 persons. The Kentucky average is one physician to every 1,022 persons.

It should be noted that the statistics include, not only practicing physicians, but also those physicians in government facilities, teaching institutions, hospitals, etc. The only physicians excluded in the figures are interns and public health officers.

County	1970 Population	1960 Population	July, 1970* Physician	Population	1970 Physician-Population Ratio	Category**
Adair	12,749	14,699	6	2,125		C
Allen	12,393	12,269	5	2,479		C
Anderson	9,231	8,618	4	2,308		C
Ballard	7,969	8,291	3	2,656		C
Barren	27,676	28,303	22	1,258		B
Bath	9,041	9,114	4	2,260		C
Bell	31,604	35,336	28	1,130		B
Boone	32,272	21,940	17	1,898		C
Bourbon	18,035	18,178	12	1,515		C
Boyd	50,838	52,163	61	833		A
Boyle	20,351	21,257	28	727		A
Bracken	7,025	7,422	2	3,514		C
Breathitt	13,863	15,490	6	2,610		C
Breckinridge	14,369	14,734	6	2,394		C
Bullitt	25,002	15,726	5	5,000		D
Butler	9,432	9,586	1	9,432		E
Caldwell	12,603	13,073	6	2,100		C
Calloway	27,206	20,972	19	1,432		C
Campbell	88,149	86,803	62	1,422		C
Carlisle	5,230	5,608	2	2,615		C
Carroll	8,387	7,978	5	1,677		C
Carter	19,496	20,817	2	9,745		E
Casey	12,608	14,327	4	3,152		C
Christian	55,539	56,904	61	933		A
Clark	24,473	21,075	13	1,883		C
Clay	17,601	20,748	6	2,933		C
Clinton	7,704	8,886	2	3,852		D
Crittenden	8,253	8,648	1	8,253		E
Cumberland	6,681	7,835	2	3,341		C
Daviess	78,327	70,588	72	1,088		B
Edmonson	8,482	8,085	2	4,241		D
Elliott	5,721	6,330	2	2,861		C
Estill	12,526	12,466	3	4,175		D
Fayette	172,927	131,906	562	308		A
Fleming	10,398	10,393	3	3,466		C
Floyd	34,751	41,642	22	1,534		C
Franklin	32,749	29,421	36	909		A
Fulton	10,132	11,256	9	1,126		B
Gallatin	3,992	3,867	1	3,992		D
Garrard	9,311	9,747	2	4,655		D
Grant	9,485	9,489	4	2,741		C
Graves	30,745	30,021	17	1,809		C
Grayson	15,880	15,834	7	2,911		C
Green	9,970	11,249	7	1,424		C
Greenup	33,200	29,238	9	3,688		D
Hancock	6,832	5,330	2	3,416		C
Hardin	76,614	67,789	46	1,668		C
Harlan	35,596	51,107	49	728		A
Harrison	13,959	13,704	9	1,552		C
Hart	13,448	14,119	6	2,261		C
Henderson	35,329	33,519	30	1,177		B
Henry	10,593	10,987	3	3,531		C
Hickman	5,874	6,747	2	2,937		C
Hopkins	37,090	38,458	53	700		A
Jackson	9,796	10,677	1	9,796		E
Jefferson	689,975	610,947	1,011	673		A
Jessamine	16,760	13,625	4	4,190		D
Johnson	16,845	19,748	11	1,531		C
Kenton	128,655	120,700	126	1,021		B
Knott	15,306	17,362	2	7,653		E
Knox	23,547	25,258	9	2,616		C
Larue	10,566	10,346	4	2,642		C
Laurel	26,913	24,901	11	2,447		C
Lawrence	10,407	12,134	10	1,041		B
Lee	6,400	7,420	1	6,400		E

County	1970 Population	1960 Population	July, 1970* Physician Population	1970 Physician Population Ratio	Category**
Leslie	11,383	10,941	5	2,277	C
Letcher	22,590	30,102	18	1,255	B
Lewis	12,176	13,115	2	6,088	E
Lincoln	16,053	16,503	3	5,351	D
Livingston	7,391	7,029	4	1,848	C
Logan	21,501	20,896	11	1,955	C
Lyon	5,126	5,924	4	1,281	B
McCracken	58,571	57,306	77	761	A
McCreary	12,201	12,463	2	6,101	E
McLean	8,789	9,355	4	2,197	C
Madison	43,629	33,482	26	1,680	C
Magoffin	9,782	11,156	4	2,446	C
Marion	16,064	16,887	9	1,785	C
Marshall	19,639	16,736	10	1,964	C
Martin	9,150	10,201	3	3,050	C
Mason	17,157	18,454	15	1,144	B
Meade	17,948	18,938	2	8,974	E
Menifee	3,936	4,276	0	3,936	D
Mercer	15,716	14,596	11	1,429	C
Metcalfe	7,797	8,367	2	3,899	D
Monroe	11,353	11,799	8	1,419	C
Montgomery	15,226	13,461	10	1,523	C
Morgan	9,736	11,056	3	3,245	C
Muhlenberg	27,074	27,791	13	2,083	C
Nelson	23,167	22,168	10	2,317	C
Nicholas	6,379	6,677	3	2,126	C
Ohio	18,213	17,725	10	1,821	C
Oldham	14,104	13,388	10	1,410	C
Owen	7,248	8,237	2	3,624	C
Owsley	4,839	5,369	1	4,839	D
Pendleton	9,722	9,968	2	4,861	D
Perry	24,373	34,961	18	1,354	B
Pike	58,876	68,264	59	999	B
Powell	7,630	6,674	1	7,630	E
Pulaski	34,541	34,403	29	1,189	B
Robertson	2,094	2,443	0	2,094	C
Rockcastle	12,054	12,334	2	6,027	D
Rowan	16,364	12,808	11	1,488	C
Russell	10,279	11,076	3	3,426	C
Scott	18,073	15,376	7	2,582	C
Shelby	18,869	18,493	7	2,695	C
Simpson	12,542	11,548	7	1,792	C
Spencer	5,414	5,680	3	1,805	C
Taylor	16,898	16,285	7	2,414	C
Todd	10,761	11,364	3	3,587	C
Trigg	8,397	8,870	6	1,399	B
Trimble	5,114	5,102	2	2,557	C
Union	15,587	14,537	4	3,897	D
Warren	53,916	45,491	54	998	A
Washington	10,533	11,168	4	2,633	C
Wayne	13,911	14,700	5	2,782	C
Webster	12,765	14,244	4	3,191	C
Whitley	23,501	25,815	21	1,119	B
Wolfe	5,347	6,534	2	2,673	C
Woodford	14,121	11,913	9	1,569	C

* Physician figures obtained from July 1, 1970, report submitted by Kentucky State Medical Licensure Program.

** Category Explanation:

A — 10 counties with highest physician-population ratio.
(A — 308 - 998)

B — 11th through 25th counties with next to highest physician-population ratio.
(B — 999 - 1,397)

C — 70 counties in middle classification category.
(C — 1,398 - 3,624)

D — 11th through 25th counties next to lowest in physician-population ratio.
(D — 3,688 - 5,351)

E — 10 counties with lowest physician-populaton ratio.
(E — 6,027 - 9,796)

Bennett L. Crowder II, M.D. is now practicing general and thoracic surgery in Hopkinsville. He received his M.D. at the University of Tennessee in 1961. After completing his residency at the Mayo Graduate School of Medicine, he served with the U.S. Army for two years.

Charles K. Davis, Jr., M.D. is now in association with William H. Hosbach, M.D., in Paducah. Doctor Davis graduated in 1964 from Vanderbilt University, then took his internship and residency at Vanderbilt University Hospital. He specializes in general, thoracic and vascular surgery.

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(Continued from page 584)

carcinoma. As yet, no procedure has made much difference in patients with anaplastic carcinoma.

It is probably worthwhile to treat the patient with pure and mixed papillary carcinoma with thyroid post-operatively to suppress thyroid stimulating hormone. This effect has been shown to have beneficial effect on metastases.

Even when disease is left after surgery, the growth is slow and survival long. Consequently, this necessitates a long observation period to judge the prognosis of this tumor and to rule out any residual or recurrent carcinoma.

Summary

A series of 133 cases of thyroid nodules, of which 25 were carcinoma, is reviewed. The incidence of carcinoma is near 20 per cent. One half of the men with thyroid nodules had thyroid carcinoma. When the thyroid nodule was associated with palpable cervical lymph nodes, the probability of thyroid carcinoma proved to be very high.

References

1. Richey, O. L., Jr., and Howard, R. B.: Cancer of the Thyroid, *Amer. J. Surg.*, 112:637, Nov., 1966.
2. Alrich, E.M.: Carcinoma of the Thyroid, *Amer. J. Surg.*, 109:736, June, 1965.
3. Fry, W.J., O'Neal, R.M., Schmidt, R.W., and DeWeese, M.S.: Cancer of the Thyroid, *Surg. Clin. N. Amer.*, 41:1191, Sept-Oct., 1961.
4. Medina, R.G. and Elliott, D.W.: Thyroid Carcinoma, An Analysis of 130 Cases, *Arch. Surg.*, 97:239, Aug, 1968.
5. Wilson, S.M., Platz, C., and Block, G.M.: Thyroid Carcinoma After Irradiation, *Arch. Surg.*, 100:330, April, 1970.
6. Block, M.A., Horn, R.C., Jr., Miller, J.M., Barrett, J.L., and Brush, B.E.: Familial Medullary Carcinoma of the Thyroid, *Ann. Surg*, 166:403, Sept., 1967.
7. Fletcher, J. R.: Medullary Carcinoma of the Thyroid Gland, *Arch. Surg.*, 100:257, March, 1970.
8. Buckwalter, J.A.: Surgical Treatment of Thyroid Carcinoma, *Arch. Surg.*, 98:579, May, 1969.
9. Colcock, B.P., and Adams, H.D.: Thyroid Surgery for Benign and Malignant Disease, *Surg. Clin. N. Amer.*, 45:533, Sept., 1965.
10. Hutter, R.V.P., Frazell, E.L., and Foote, F.W.: Elective Radical Neck Dissection: An Assessment of its use in Management of Papillary Thyroid Cancer, Ca-A. *Cancer Journal for Clinicians*, 20:87, March-April, 1970.
11. Marchetta, F.C., and Sako, K.: Modified Neck Dissection for Carcinoma of the Thyroid Gland, *Surg. Gynecol. Obstet.*, 119:441, Sept., 1964.
12. Tollefsen, H R., and DeCosse, J.J.: Papillary Carcinoma of the Thyroid, *Amer. J. Surg.*, 106:728, Nov., 1963.

Russell E. Teague, M.D.

(Continued from page 602)

of this Board and a detailed recommendation was prepared by KMA, but no action was taken during the 1970 legislative session. The Constitution and functions of the Board therefore remain the same as before. Much thought was given by this Board during the past year toward the selection of a successor to the office of Commissioner of Health upon Doctor Teague's anticipated retirement. A careful screening of every qualified Public Health Specialist in Kentucky was made. Finally William P. McElwain, M.D., was selected. During Doctor Teague's disability, with the endorsement of Governor Nunn, Doctor McElwain was appointed acting Commissioner until September 1, 1970, when he became Commissioner of Health.

We commend Doctor Teague on a long and highly effective service to society, and in particular, to every citizen of Kentucky. In his retirement he must surely reflect with a justifiable pride and satisfaction upon a useful and distinguished career. It is hoped that he may yet be available as a consultant so that he may help in the perplexing situations that will continue to confront us. During the past 14 years he has rendered a magnificent service to our people.

SAM A. OVERSTREET, M.D.

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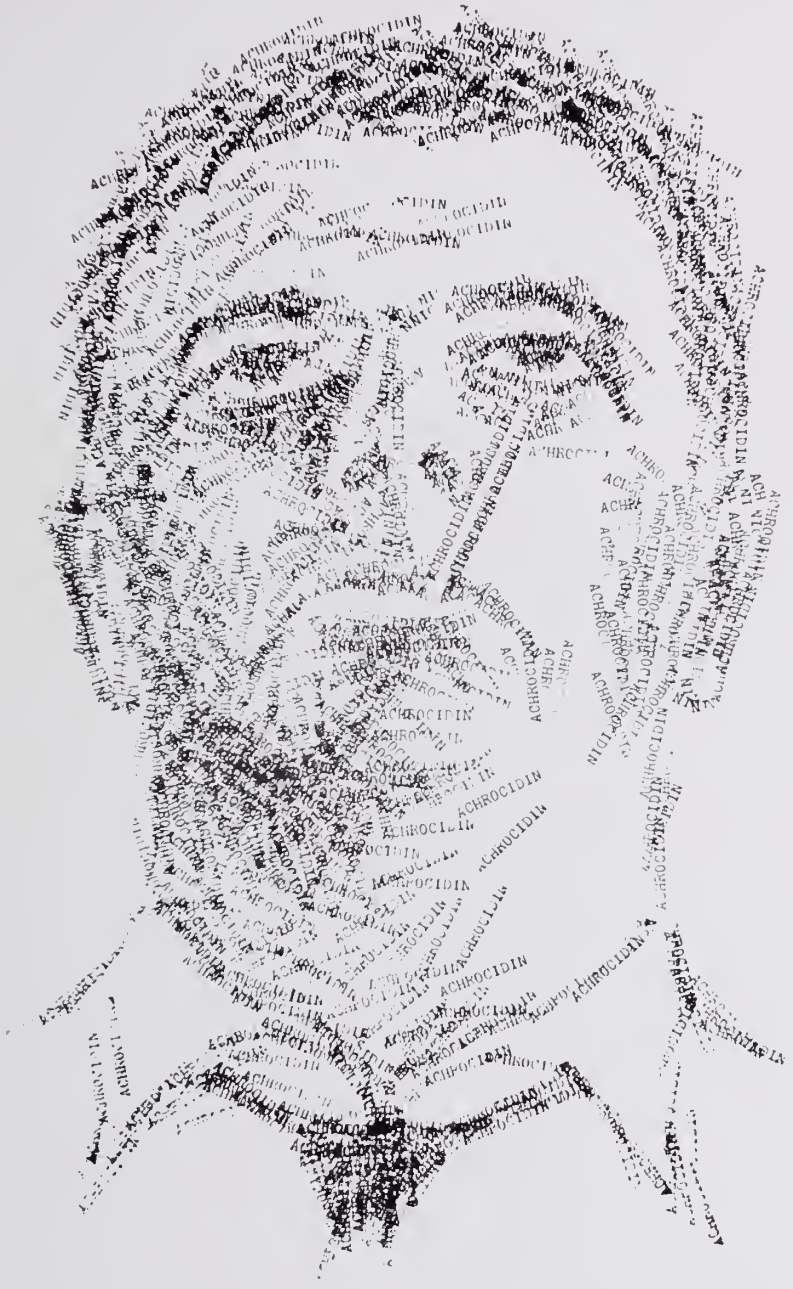
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
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The Journal of The KENTUCKY Medical Association



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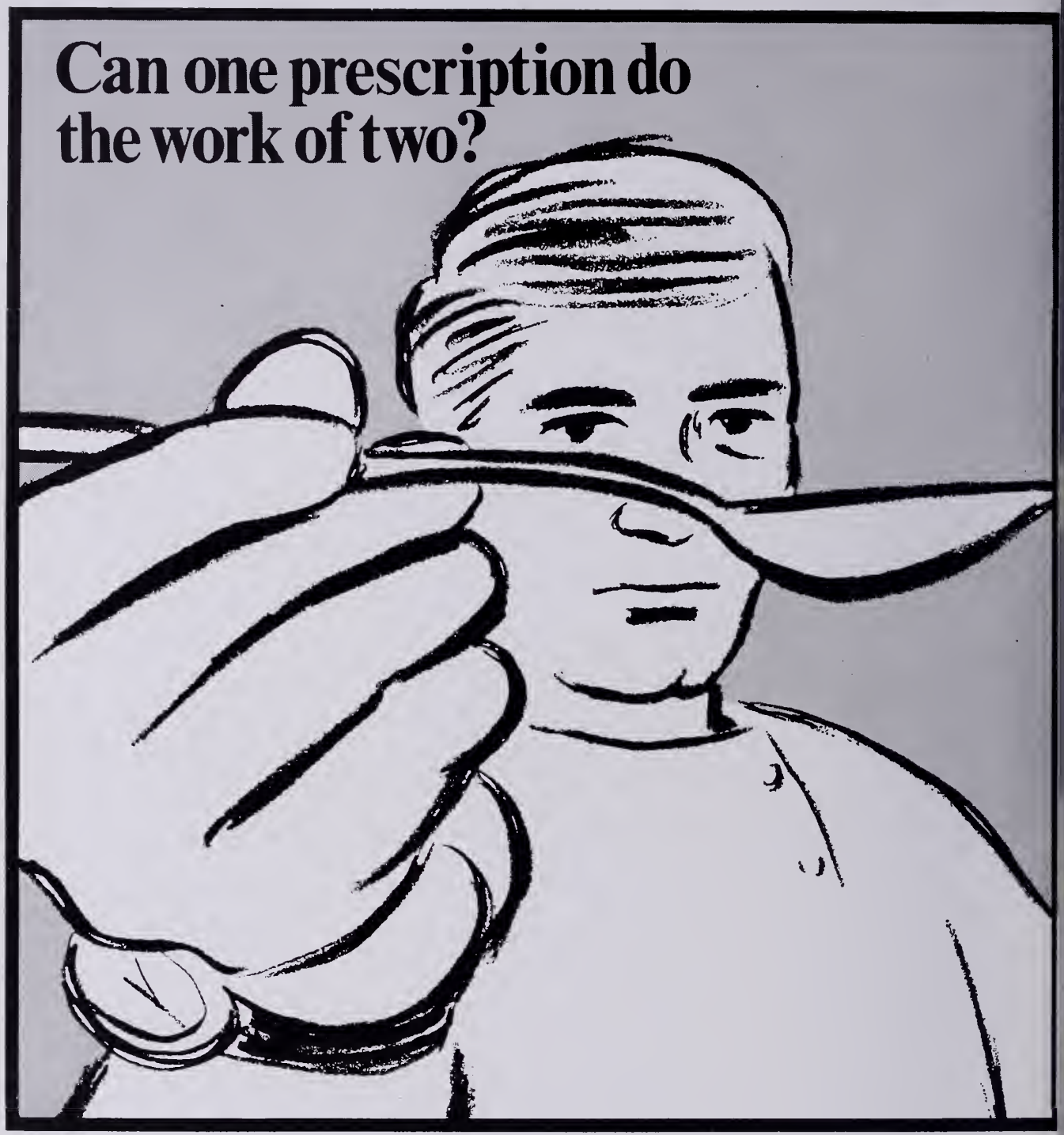
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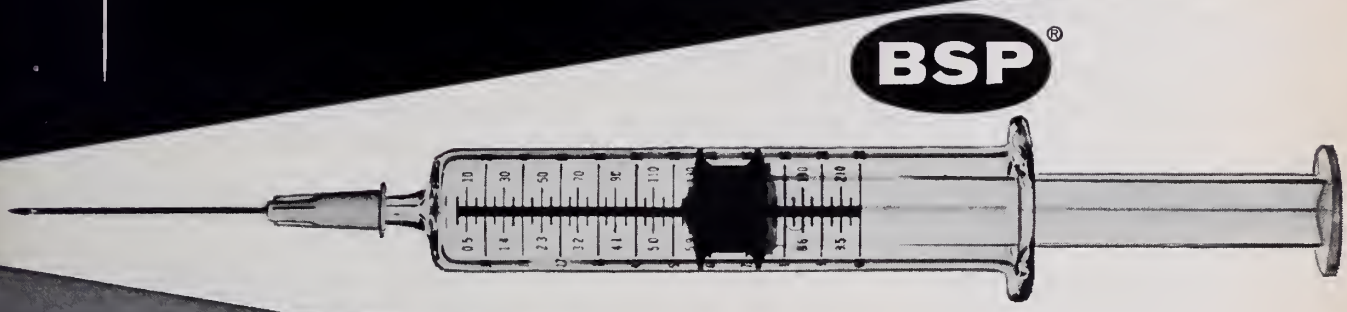
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Louisville, Ky. 40205
Phone (Area Code 502) 452-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

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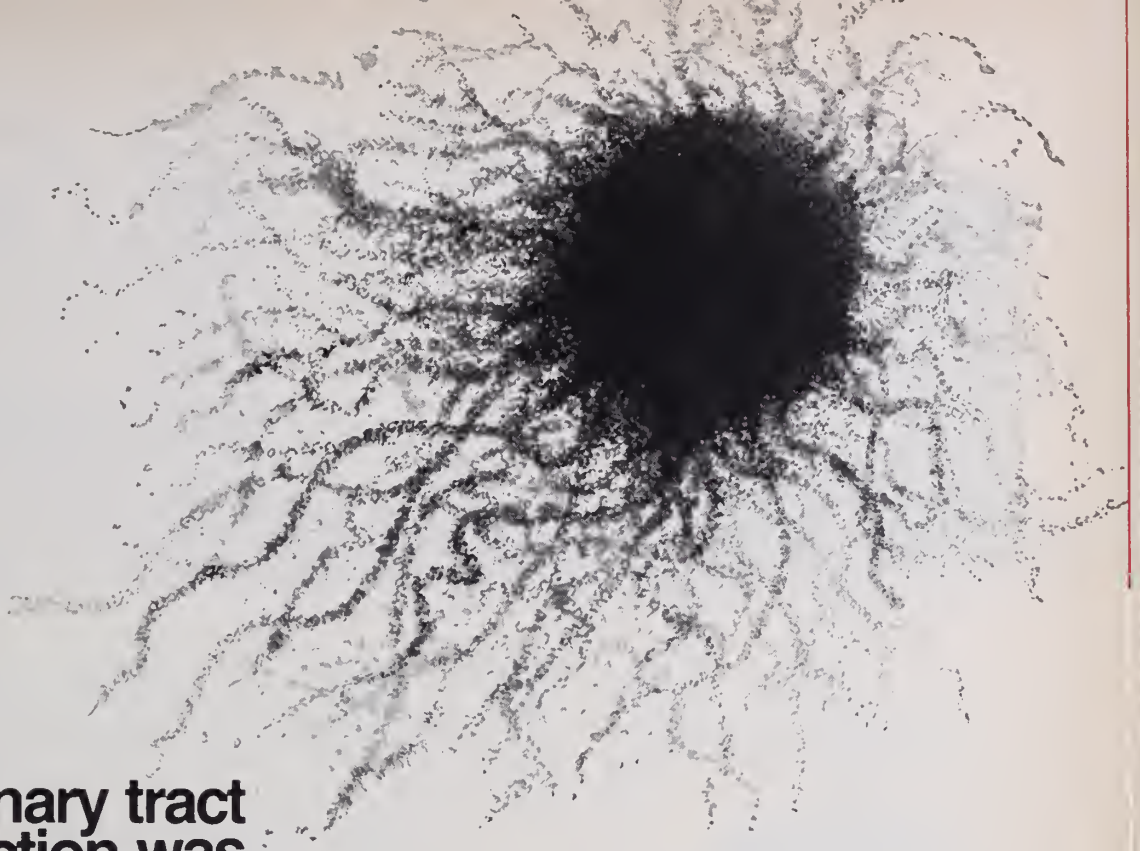
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MESSAGE FROM THE PRESIDENT



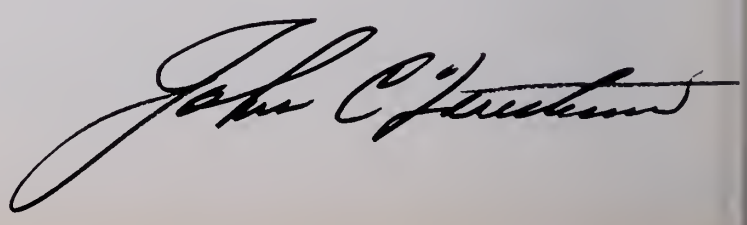
Delivery Of Medical Care

In the June 25 issue of the *New England Journal of Medicine,* Mr. Walter . McNerney, president of the American Blue Cross Association, had this to s about the regimentation of physicians to relieve the problem of delivery health care: "Although the mood of the new phase will rest on a great deal local initiative, some BOLD NEW INTERVENTIONS FROM WASHINGTC will be needed to solve depressed area problems with reasonable dispatch; f example, through SELECTIVE SERVICE ASSIGNMENTS or domestic pea corps programs built around neighborhood centers liberally supported by fede money. The accumulated deficit (in health delivery) is that great."

Mr. McNerney has a wide audience and is listened to with respect by su health planners as the committee consisting of the late Walter Reuther, a Senators Ted Kennedy, John Sherman Cooper, et al. This committee, like ma other sources, disregards the resultant, certain chaos for the sake of making th plan into law.

However, an encouraging note was sounded from a surprising quarter—fr the office of the assistant secretary of HEW. In an interview for *Americ Medical News,* Roger Egeberg, M.D., in stating that HEW's "plan" was to g ready for NHI rather than to offer it to the people, (as if everyone has alrea conceded its inevitability), further says: "If doctors were dominoes and if y had all the nurses and other assistants you need, you could say: we're goi to offer national health insurance. But doctors are not dominoes, and you're n going to change the pattern of life behavior of many doctors over 50 or 5 And an awful lot of doctors are over the age 55—they don't get into pract until their middle 30's." He observed, too, "I would say that 80 per cent of t doctors, who perhaps are earning more money than others would like to see the make, are earning it at a rate that isn't a lot higher than that of a plumber. They earning it by working 75 and 80 hours a week."

Thank you Doctor Egeberg.



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Printe

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 12-68. This 43 year old married white, gravida 8, para 7, was under the care of a private physician. She had had regular prenatal visits. EDC was June 26, 1968. She was Rh+; hematocrit was 37 per cent. Weight gain during this pregnancy was 11 pounds. Her other pregnancies were cared for by another physician who had died.

She was admitted to the hospital at 4:15 a.m. July 10, 1968. Vaginal bleeding occurred at home with the passing of some clots. She was examined and found not to be in labor. The cervix was not dilated and no bleeding was observed. Later that day she again had some vaginal bleeding; the abdomen remained soft, non-tender; and the fetal heart tones were good. The bleeding continued; the amount wasn't stated. At 9 p.m. a decision was made to induce labor. She received "thytuitary extract" subcutaneously. Contractions began and at 10:10 p.m. she was taken to the delivery room three fingers dilated with bulging membranes. The membranes were ruptured artificially; following this there was a large amount of bleeding. A diagnosis of abruptio placentae was made. Examination revealed the fetal vertex at a high station. The fetal heart was quite slow and irregular. It was decided to attempt an internal podalic version and breech extraction. This was accomplished under chloroform anesthesia with considerable difficulty. The infant was delivered at 10:42 p.m. weighing eight pounds, ten ounces. Initially it was slow to breathe. However, it did well following resuscitation. An Erb's palsy of the right arm was present and the baby was transferred to another hospital for treatment.

Blood lost during delivery was great. Blood pressure dropped precipitously after the delivery and an intravenous drip with oxytocin was started; oxygen was administered. The patient did poorly. A cutdown was performed, but functioned poorly due to vascular collapse. She received Wyamine, Coramine and continuous oxygen by positive pressure. However, blood pressure remained low, less than forty mm. of mercury, and in spite of attempts to administer fluids, blood and pressor substances, she expired at 1:20 a.m. July 11, 1968.

There was no autopsy. The cause of death was listed as pulmonary embolus.

Comment

The Committee considered this case an obstetrical preventable maternal mortality with preventable factors on the part of the physician. The first preventable factor discussed by the Committee was the poor judgement in attempting internal podalic version in this situation, with a high fetal vertex, a large infant, and an incompletely dilated cervix. Another factor was inadequate fluid and blood replacement at the time of the delivery, to prevent the subsequent shock that occurred. The blood loss was described as "great." Although the cause of death is listed as pulmonary embolus, it was felt by the Committee that this was a case of exsanguination from a vaginal laceration or uterine rupture. This again shows the value of autopsy, for we can't be certain without one. However, this patient should have been properly examined both vaginally and abdominally to determine if blood were present in the peritoneal cavity.

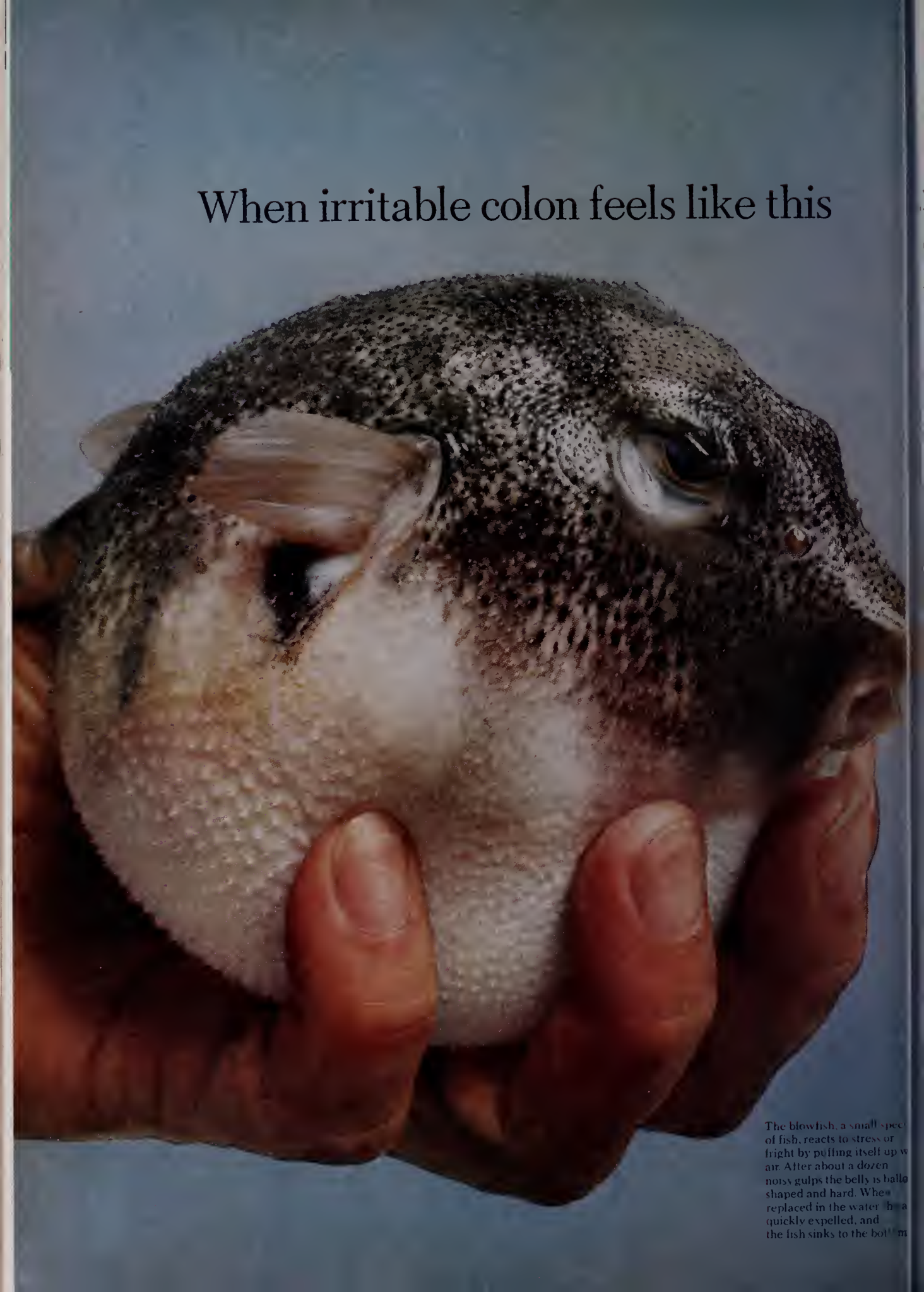
Internal podalic version has been relegated to the rare case in obstetrics today. Perhaps the only indications for internal podalic version are in the second twin when the cervix is completely dilated, or possibly with a small premature or immature infant that has little chance of survival. Not only is the potential harm to an infant great, but a high incidence of maternal damage occurs. Difficult and traumatic manipulation under anesthesia are necessary to perform a version on a large infant. This results in a high incidence of cervical, uterine and vaginal lacerations. The Committee therefore felt that Cesarean Section was the method that should have been used to deliver this infant when abruptio placentae was diagnosed and the decision for delivery made. This would have been far safer for both mother and infant.

Postpartum hemorrhage remains a leading cause of obstetrical morbidity and mortality. This case again emphasizes what numerous studies have shown. There is ample time to rescue the patient undergoing profuse bleeding. This patient was delivered at 10:42 p.m. and did not die until 1:20 a.m. Over two hours of time were available to institute proper therapy. Beecham[1] showed in his study of 52 deaths occurring from post partum hemorrhage in Philadelphia that the average interval between delivery and death was 5 hours and 20 minutes. Only six patients died within two hours of delivery and no one died within one and one-half hours of delivery. In these cases, as in the present case, there was time for proper diagnosis and intensive treatment. Frequently, as probably occurred in this case, the blood loss was not appreciated; but when hypotension occurs postpartum blood loss, whether internal or external, must be properly diagnosed, ruled in or out, and appropriate measures undertaken.

References

1. Beecham, C. T.: Postpartum Hemorrhage as a Cause of Death; *Am. J. OB-GYN*, 32:258, 1939.

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A Link in the Chain

auxiliary

Mrs. Charles E. Hornaday, Owensboro, was installed as president of the Woman's Auxiliary to KMA during the Annual Meeting, September 22-24. She will be writing the "A Link in the Chain" page for the Journal during the 1970-71 organizational year.



Mrs. Hornaday

The auxiliary program is not planned simply by intuition. A national auxiliary program development committee, created in 1966, works closely with AMA. It studies current, past, and proposed auxiliary activities, evaluating them as to timeliness, need, and continuing concerns of AMA, and demonstrated interest of state auxiliaries. It recommends to the Board of Directors the course our national auxiliary should follow, what phases of our work should be emphasized, what programs may have outlived their usefulness and should be phased out, and what activities might be added. The committee seeks to draw needed information from knowledgeable people, both in and out of the auxiliary.

The plan results in broad guidelines being set up which individual states are invited to follow; however, each state is encouraged to interpret auxiliary work in terms of local needs.

In Kentucky we have tried to formulate a program with built-in flexibility. We encourage suggestions and criticism. The three immediate past presidents of KMA are our advisors.

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Medical Progress

Renal Hypertension

Robert G. Luke, M.D.*

In every patient with hypertension the practitioner is faced with the question, "Is this hypertension renal in origin?" Some, indeed, believe that renal mechanisms underlie hypertension in all patients; and there are subtle changes in renal function in "essential hypertension"; but whether these constitute cause or effect remains to be established. From experimental work two mechanisms of renal hypertension can be invoked: (1) production by the kidney of pressor substances such as renin (2) failure of physiological renal mechanisms which lower systemic blood pressure (a renal medullary vasodepressor substance is under active investigation). Hypertension may also be accentuated in some patients by renal retention of sodium and water.

From the practical viewpoint renal hypertension can be divided into: (1) hypertension secondary to bilateral parenchymatous renal disease, such as chronic glomerulonephritis, chronic pyelonephritis and polycystic kidneys and (2) renovascular hypertension, which can be defined as hypertension caused by occlusive disease of the renal arterial vasculature, which is potentially curable by either reconstructive vascular surgery or by nephrectomy. It is of major importance to the patient that these be clearly differentiated.

Renal Hypertension Secondary to Bilateral Parenchymatous Renal Disease

Although surgery cannot cure this type of renal hypertension, the underlying diagnosis should be established. This type of hypertension is common in young patients; indeed, certainly in the white population, it may be the most common cause of hypertension seen in the young. Even slight hypertension may be the presenting feature which leads to the diagnosis of underlying chronic renal disease. There may be a family history of polycystic kidneys or a past history of acute glomerulonephritis, or of symptoms suggestive of urinary tract infection. Frequently, however, there is no helpful history. Polycystic kidneys may be palpable, although, in the early stages of the disease, diagnosis may depend on an intravenous pyelogram. Urinalysis is of great importance: chronic glomerulonephritis is always associated with significant proteinuria and usually with red cells and granular casts; whereas patients with chronic pyelonephritis may have no, or minimal, proteinuria, with pyuria and white cell casts. With polycystic kidneys the only abnormality in the urine may be microscopic hematuria; proteinuria may or may not be present. There are now new methods of treatment of chronic glomerulonephritis and, unless the disease is end-stage with very severe impairment of renal function, renal biopsy is usually indicated to determine prognosis and treatment. Patients with urinary tract infection need a full urological assessment to exclude congenital or obstructive disease of the pelvis, ureter, bladder, or urethra. While there is no specific treatment for polycystic kidney disease these patients should be followed carefully for superimposed urinary tract infection and for hypertension and other complications of chronic renal disease, so that effective and early treatment can be instituted.

Successful treatment of the underlying bilateral renal disease may be associated with amelioration or cure of the hypertension. For example, patients with glomerulonephritis secondary to systemic lupus erythematosis often

*Associate Professor; Director, Renal Division, Department of Medicine, College of Medicine, University of Kentucky

respond to prednisone and/or azathioprine with improvement in renal function and subsequent improvement in hypertension. This is also true of some patients with polyarteritis nodosa, but scleroderma and the associated hypertension is usually resistant to treatment.

Even when there is no specific treatment available for the underlying renal disease, hypertension complicating bilateral renal disease should be detected early and treated. Such hypertension more commonly goes on into a malignant phase than does essential hypertension; further a "vicious circle" hypertension is soon set up whereby hypertension damages the renal vasculature, producing further renal ischemia, which in turn produces more severe hypertension. Thiazide diuretics are reasonably effective when renal function is not too impaired, but when the serum creatinine rises above 4 to 5 mg/100 ml they are often less effective. Restriction of dietary salt is usually indicated. If the hypertension is associated with sodium and water retention with edema, more powerful diuretics, such as furosemide, have to be employed to obtain natriuresis when glomerular filtration rate is markedly depressed (<20 ml/min, BUN > 50 mg/100 ml). In my experience, methyldopa is the best drug for treatment of this type of renal hypertension. If the BUN is above about 60 mg/100 ml, the initial dosage employed should be less than is usual (starting with 125 mg twice daily), as methyldopa is more potent in some patients with renal failure than in patients with normal renal function. Hydralazine can also be used but, in the long term, it is more often associated with side effects, such as nausea and vomiting.

It is sometimes difficult to differentiate primary renal disease with secondary hypertension from essential hypertension with renal impairment due to nephrosclerosis. If the patient is relatively young, and has only moderate hypertension which has been present for no more than a few years, significant proteinuria usually implies primary renal disease. However, if the patient has long standing hypertension, especially in the older age groups, nephrosclerosis is likely. Malignant hypertension, regardless of cause, is commonly associated with renal impairment and proteinuria, which is sometimes quite severe, even in the absence of primary renal disease.

Malignant hypertension should always be treated vigorously, even when renal function is severely impaired. Every effort should be made to keep the diastolic blood pressure in the 90 to 100 mm Hg range. When malignant hypertension is associated with acute severe impairment of renal function, peritoneal or hemodialysis can justifiably be employed for a few weeks, to determine if reduction of blood pressure can allow healing of hypertensive vascular renal lesions, and so permit some improvement in renal function. When renal function is irreversibly compromised the patient should be considered, where appropriate, for chronic dialysis and/or renal transplantation; malignant hypertension is not a contraindication, by itself, to either of these methods of treatment. Regular dialysis treatment, together with rigid salt and water restriction, controls malignant hypertension in about 80% of patients; in the remaining 20% bilateral nephrectomy may be required in order to obtain control of the blood pressure. Plasma renin levels are usually exceptionally high in this latter group.

Renovascular Hypertension

There are three clinical types of renovascular hypertension: (1) renal artery stenosis, which is associated with an 80% cure or improvement rate when patients are properly selected; (2) unilateral pyelonephritis, which is associated with an approximately 50% benefit; (3) and a miscellaneous group including hydronephrosis, renal tuberculosis, and renal carcinoma, in which the main reason for surgery is usually a urological one, and in 20% of whom an incidental effect on hypertension is obtained. At present renovascular hypertension is easily the most common cause of hypertension amenable to surgical treatment. Nevertheless it occurs in probably no more than 5% of the general hypertensive population.

Renal Artery Stenosis

There is now over a decade of experience in the diagnosis and treatment of renal artery stenosis. An incidental, merely anatomical, stenosis which is common in the older age groups, even in the normotensive population, must be differentiated from a functionally active stenosis which is compromising renal blood flow and "turning on" renovascular mechanisms. The anatomical appearance of the stenosis on renal angiography cannot be depended

upon alone as an indication for surgery. Distal to a functionally active stenosis there is reduction in glomerular filtration rate, an increased percentage tubular reabsorption of sodium and water, and hence diminished urine flow, diminished urine sodium and increased urine creatinine or inulin as compared to the normal side. These functional changes produce characteristic alterations in the hypertensive IVP with early minute sequence films, in the isotope renogram and scan, in divided renal function tests, and are associated with increased renal vein renin concentrations on the affected side.

There is no typical clinical syndrome associated with hypertension due to renal artery stenosis; the hypertension may range from the most mild to the most severe in any age group. Even a strong family history of essential hypertension does not rule out significant renal artery stenosis. The only worthwhile clinical clue is a bruit over the renal arteries; this may also arise in other atherosclerotic abdominal vessels. Proteinuria is absent in renovascular hypertension unless the hypertension produced is of the malignant type. Thus, the practitioner is dependent largely on screening tests for the diagnosis of this important cause of remediable hypertension. Renal angiography is clearly not suitable as a screening test; and peripheral cenous renins, so far, have also not proven satisfactory. We are thus still dependent for screening on a well performed hypertensive IVP, supplemented, if possible, by an isotope renogram and scan. Taken together, these procedures can reasonably rule out main stem renal artery stenosis. When only a segmental branch of the renal artery, or an aberrant renal vessel, are stenosed, these tests may be falsely negative; fortunately, however, this is a relatively rare cause of renovascular hypertension. Thus, unless the patient is in a relatively young age group with severe hypertension, or there is some clinical indicator such as a renal bruit, the practitioner does not normally have to proceed to renal angiography to reasonably exclude renovascular hypertension. However, his level of clinical suspicion should be high; selective renal angiography is a reasonably safe procedure in experienced hands. In many centers divided renal function tests are now only carried out when the results of other tests are equivocal, or where it is essential to know the comparative excretary function of the two kidneys. Increasing emphasis is being placed on studies of renal venous renin activity, which are obtained by catheterizing both renal veins. Information is still accumulating on these tests, but it appears that a ratio of about 2 to 1 for the renal venous renin activity (between the renal artery stenosis kidney and the normal kidney) is associated with an excellent prospect of surgical cure of hypertension.

Before embarking on expensive and potentially hazardous tests such as aortography, differential renal function tests, and renal venous renin estimations, three issues should be clarified. First the patient should have significant hypertension which is a threat to that patient's subsequent health; secondly, the patient should be fit for surgery and, in particular, not have evidence of major ischemic vascular disease elsewhere, especially in the heart or brain; and thirdly, renal function should be adequate to permit nephrectomy, should that procedure be required, if reconstructive vascular surgery is not possible. As a general rule, if the BUN is above 30 mg/100 ml or the creatinine clearance is less than about 50 ml/min, a search for a renovascular basis for hypertension is not justified, except in acute, malignant phase, hypertension when some of the renal impairment may be reversible if the hypertension can be controlled.

An important advance in the therapy of renal artery stenosis has been the realization that these patients respond as well, or as badly, to drug therapy as do patients with essential hypertension. Particularly in the older patient with an atherosclerotic renal artery stenosis, drug therapy offers a real alternative to surgery. Reconstructive vascular surgery is associated with a significant operative risk in such a patient. If the patient does poorly on drugs, surgery seems more justifiable. Surgery normally appears the treatment of choice in the younger patient with renal artery stenosis due to fibrous dysplasia of the renal artery. Reconstructive vascular surgery of the kidney demands an experienced surgeon; the best combination may well be a urologist and a vascular surgeon. It is normally preferable to nephrectomy if the patient is fit for the procedure, unless the kidney is extremely small or the disease process involves the distal branches of the renal vessel.

Unilateral Pyelonephritis

The patient with unilateral pyelonephritis may or may not give a history suggestive of previous urinary tract infection. The main difficulty in assessing such patients is the proof that the disease is in fact unilateral; compensatory hypertrophy in the opposite kidney with a normal pelvi-calyceal system is encouraging evidence of the integrity of that kidney. Because it is more difficult to forecast benefit from surgery in unilateral pyelonephritis, as compared to properly selected cases of renal artery stenosis, I believe that one should rarely remove a pyelonephritic kidney which is contributing more than 25% of total renal function. The more severely the kidney is damaged the more justifiable is nephrectomy. Slightly damaged pyelonephritic kidneys should not be removed to treat hypertension without the most compelling of clinical indications. Removal of a nonfunctioning kidney may still be associated with benefit since such kidneys can still function as an "endocrine organ" because of capsular blood flow.

In conclusion, it is evident that exciting and major advances have occurred in the field of renal hypertension over the past decade. Although the pathogenesis of renovascular hypertension is not yet definitely established, we can detect patients with this syndrome with reasonable safety and certainty and can treat them effectively. We also have much more to offer the patient with underlying bilateral renal disease: drug therapy in the treatment of hypertension is more tolerable and effective, and, in some patients at least, we can treat the underlying disease process in the kidney. Finally, where hypertension accompanies terminal rental disease we now have the capacity, in a still admittedly distressingly small percentage of patients, to offer full rehabilitation with dialysis therapy, nephrectomy, and renal transplantation.

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Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

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VOLUME 68 OCTOBER 1970 No. 10

Therapy in Wilms' Tumor of Childhood

PHILLIP HOLLAND, M.D.* and ARTHUR HELLEBUSCH, M.D.**

Lexington, Kentucky

The clinical manifestations and treatment of seven children with resectable Wilms' tumor is reported. The absence of disease recurrence to date suggests that with current therapy involving the use of Dactinomycin, optimism is justified in this form of childhood malignancy.

IN the recent past, seven children with Wilms' tumor have been treated at the University of Kentucky Medical Center. Results have been encouraging in that all seven children are without evidence of recurrent disease to date. This report describes the clinical manifestations and management of these children and reviews the results of current therapy in larger patient series.

Patient Material

Three case histories are presented in detail and pertinent data of the seven patients is summarized in Table 1.

Case 1: J.S., a three-year-old white male, was first seen at the University of Kentucky Medical Center (UKMC) on October 7, 1966, following minor abdominal trauma due to an accidental fall. A large left flank mass and a small right lower quadrant abdominal mass were palpable at the time of admission. The physical examination was otherwise within normal limits. On intravenous pyelogram, no dye excretion was noted in the left kidney, and blunting of the right calicecal system was present. The child was taken to the operating room with a provisional diagnosis of bilateral Wilms' tumor. A left nephrectomy and partial right nephrectomy were performed following frozen section diagnosis of Wilms' tumor. Excision of a large mesenteric node was read as negative for Wilms' tumor. At the time of surgery and in a four-week postoperative period he received Dactinomycin (Actinomycin D) in a total of 100 micrograms per kilogram body weight. Postoperatively, he received radiotherapy in a dose of 2,500 rads over a six-week period. He has had multiple outpatient evaluations, including repeat intravenous pyelogram, creatinine clearances and chest films, and was last seen on May 20, 1970, three years and seven months after nephrectomy. No evidence of disease recurrence has been documented.

Case 2: J.L., a three-month-old white male, was admitted to the UKMC on November 13, 1967, following detection of an abdominal mass by his family physician. A large smooth, right flank mass which was dull to percussion and did not transilluminate was palpable. Otherwise, physical examination was within normal limits. A right intrarenal mass was observed on intravenous pyelogram. On November 14, 1967, the child underwent exploratory laporotomy, and a right nephrectomy was performed following frozen section diagnosis of Wilms' tumor. Dactinomycin was administered during the surgical procedure and in the postoperative period in a total dose of 75 micrograms per kilogram. The patient received postoperative radiotherapy in a dose of 1800 rads to the right renal area. He has had multiple out-patient evaluations and was last seen May 20, 1970, two years and six months after

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nephrectomy. No evidence of disease recurrence has been documented.

Case 3: D.J., a five-and-one-half-year old white male, was referred to the UKMC on September 29, 1969, following a one-day bout of hematuria and palpation of a right-sided abdominal mass, by his family physician. A large, firm, smooth, non-tender mass was palpable in the right side of the abdomen. On intravenous pyelogram the right kidney was poorly visualized, although it appeared to be markedly enlarged, the calices were distorted and the lower pole of the calyx was dilated and blunted. Exploratory laporotomy was performed and, following frozen section diagnosis of Wilms' tumor, right nephrectomy was performed. Dactinomycin was given at the time of surgery and in the immediate postoperative period in a total dose of 75 micrograms per kilogram. Radiotherapy was given postoperatively in a dose of 2,500 rads to the right renal area over a three-week period. Since that time he has received two subsequent five-day intravenous courses of Dactinomycin, in a total dose of 75 micrograms per kilogram, and was last seen on April 26, 1970, seven months after diagnosis. No evidence of disease recurrence has occurred to date.

Discussion

Wilms' tumor is one of the most common abdominal neoplasms in infants and children. Abdominal or flank pain may be a presenting symptom. A palpable abdominal mass is the most frequent clinical finding and was present in all of the patients in this report. Hematuria is uncommonly reported in Wilms' tumor, however, two of our seven patients presented with gross hematuria. Early diagnosis of Wilms' tumor is essential to successful treatment and, for this reason, careful abdominal palpation, particularly in healthy-appearing infants and children, should be performed during routine physical examination.

The presence of bilaterial Wilms' tumor in children has been reported as high as 10.3 per cent.[1] One of seven patients in this series had bilateral involvement. A transabdominal approach through a transverse surgical incision with extension in the direction of the tumor not only allows direct visualization of the neoplasm's vascular supply but abdominal exploration and examination of the contralateral kidney. The frequency of bilateral disease must be kept in mind since extirpation of the lesion in one kidney with contralateral nephrectomy may be possible, as in Case 1. This patient is free of disease three years and seven months after surgery, radiotherapy and a single course of Dactinomycin.

It is difficult to obtain an accurate comparison of the overall success of various therapeutic measures for Wilms' tumor. The long term survival is influenced by age, presence of metastasis, as well as the therapeutic regime employed. The basic approach to treatment for several years has been nephrectomy followed by radiotherapy. Documentation of the potentiating effect of radiotherapy by Dactinomycin in human malignancy[2] prompted the incorporation of therapy with this drug at the time of surgery and during the period of postoperative radiation therapy in patients with Wilms' tumor. Improved prognosis with

TABLE 1

Clinical and Therapeutic Data on Wilms' Tumor In Childhood.

Patient	1	2	3	4	5	6	7
Age	3yr 9mo	3mo	5yr 8mo	13mo	9yr 10 mo	6yr 7mo	6yr 2mo
Sex	Male	Male	Male	Male	Female	Female	Female
Palpable Mass	+	+	+	+	+	+	+
Hematuria	0	0	+	0	0	0	+
Lacation:							
Right Kidney	+	+	+	+		+	+
Left Kidney	+				+		
Chest Film	Normal	Normal	Normal	Normal	Normal	Normal	Normal
Elevated BUN	+	0	0	0	0	0	0
Nephrectamy	Left, Partial right	Right	Right	Right	Left	Right	Right
Date	10/8/66	11/14/67	9/29/69	6/27/68	11/27/64	1/7/70	3/19/70
Pastaperative Irradiatian	+	+	+	+	+	+	+
Dactinamycin Therapy							
Single Caurse	+	+		+	+		
Maintenance			+			+	+
Evidence Recurrence	0	0	0	0	0	0	0

this regime has been reported.[3,4] Recently, two randomized concurrent series of patients with resectable Wilms' tumor were selected by the Children's Cancer Study Group A and treated in the following manner: Group I: nephrectomy, postoperative radiotherapy and a single course of Dactinomycin. Group II: nephrectomy, postoperative radiotherapy and maintenance Dactinomycin therapy given intermittently for 15 months.[5] Forty-eight per cent (11 of 23) of the patients in Group I had no evidence of disease recurrence and 86 per cent (19 of 22) patients in Group II had no evidence of recurrence at the time of publication. The statistically significant difference between these two modalities of drug therapy and the striking superiority of intermittent maintenance therapy in preventing recurrence of disease in this report warrant further evaluation of five-day intravenous courses of Dactinomycin given just after surgery, at six weeks and three months postoperative and every three months thereafter for 15 months. Maintenance Dactinomycin given intermittently was used in Cases 3, 6 and 7 and no recurrence of disease has been documented to date. The individual follow-up period in these three patient is relatively short and does not prove as yet that cure has been obtained. Based on the present overall results, however, optimism appears justified.

Bibliography

1. Jagasia, K. H., Thurman, W. G., Pickett, E., and Grabstaldt, H.: Bilateral Wilms' Tumors in Children. *J. Pediat.* 65: 371-376, September, 1964.

2. D'Angio, G. J., Farber, S. and Maddock, C. L.: Potentiation of X-ray Effects by Actinomycin-D. *Radiology* 73: 175-177, August, 1959.

3. Fernbach, D. J. and Martyn, D. T.: Role of Dactinomycin in Improved Survival of Children with Wilms' Tumor. *JAMA* 195: 1005-1009, March 21, 1966.

4. Farber, S.: Lasker Award: Chemotherapy in Treatment of Leukemia and Wilms' Tumor. *JAMA* 198: 826-836, November 21, 1966.

5. Wolff, J. A., Krivit, W., Newton, W. A. and D'Angio, G. J.: Single versus Multiple Dose Dactinomycin Therapy of Wilms' Tumor. *N. Eng. J. Med.* 279: 290-294, August 8, 1968.

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Nerve Pinch Injuries In Football

Thomas M. Marshall, M.D.*

Louisville, Kentucky

A so-called "nerve pinch" injury is a lateral flexion neck injury stretching ligaments and lower cervical nerve roots with associated limitation of lateral motion on the side of the injury. Long term neurological changes can result. Re-injury is common unless collar or high shoulder pad protection is used.

IT HAS been estimated that neck injuries occur in more than five per cent of the football players during a single season. This incidence is probably much higher, as the pain and symptoms produced in many cases are only fleeting and athletes don't bother to report it. A fatal outcome may result from hyperextension of the neck when the face bar of the helmet is used as a lever to force the head backward. During the 1969 season, according to the 38th annual Football Survey of Football Fatalities in the United States, there were 19 direct fatalities caused by head and neck injuries.[1]

A much less lethal and more common injury is a lateral flexion injury of the neck. This is an injury produced by a blow on the side of the head forcing it to the other side. There is immediate pain from the base of the neck to the hand with tingling sensations in the arm and inability to move the arm. In a short time these sensations disappear to leave a dull ache in the neck and shoulder. Many players shrug off the pain, grit their teeth and throw a bone-crushing block into a defender on the next play. By the time the injury is detected the damage may be considerable and it becomes apparent that the symptoms were not minor or transient. Blocking backs and interior linemen are most commonly afflicted after completing a block. A player of average build and flexibility is more likely to suffer a lateral flexion injury than either short thick-necked or limber long-necked individuals.[2] This is the injury commonly called a "nerve pinch" injury.

The term "nerve pinch" is a misnomer. The mechanism of injury is a stretching of the cervical nerves and lateral cervical ligaments when the shoulder is forced downward and the head is driven to the opposite side. The severity depends upon the degree of stretching of the nerves and ligaments. The neck and shoulder ache is usual, and neurological changes in the arm are common. Diminution of the biceps and triceps reflexes and patches of numbness in the arm may last for several months. Occasionally muscle weakness of the arm, forearm and hand may persist for more than a year. Associated with these neurological findings is a consistent limitation of lateral flexion of the neck toward the affected side due to swelling and fibrosis impairing the facet function and compressing nerve roots. There is no limitation of flexion, extension or rotation.

Even if the physician is reasonably sure of the diagnosis, a thorough check of the cervical spine in an attempt to correlate pain, neurological impairment and site of injury is recommended. The work-up should include spine films and laminography, if necessary, to rule out a fracture. Myelography may be indicated to exclude a protruded disc or nerve root avulsion in those cases with unusually prolonged symptoms. Electromyography is useful to detect possible muscle degeneration. Of course the finding of a congenital abnormality in the neck should be reason to prevent the player from continuing in football.[3]

A player who has sustained a lateral flexion injury should be prescribed exercises to strengthen the neck, shoulders and upper back. Re-injury is common and can occur with flexion to either side or even with straight compression forces as the foraminal spaces are

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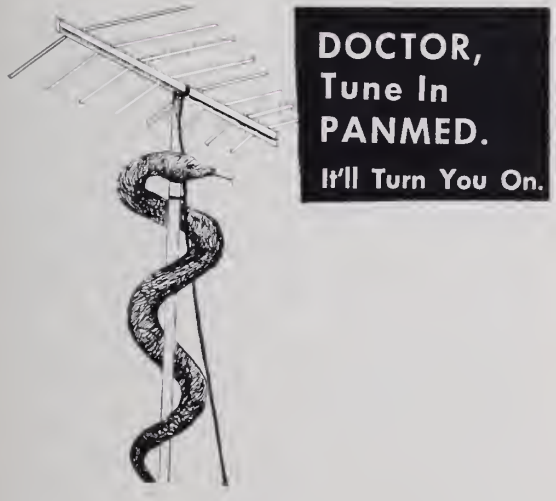
narrowed. The nerve roots are then more vulnerable to any movement which will stretch or compress them.

A Thomas collar of felt or stockinette, open in the front, should be worn by a player returning to the game after a mild lateral flexion injury. High shoulder pads with an attached soft Thomas collar will help prevent recurrence. Pads should be carefully and individually selected for each player. They should be high enough to limit the range of lateral flexion, and if they are not high enough a collar should be added. This type of equipment will also help prevent injuries resulting from sudden anterior or posterior flexion of the neck.

Treatment of the neck in the early period following the injury consists of heat and analgesics and a felt or stockinette collar most of the time. Traction sometimes helps. If weakness of the arm persists, contact sports should be avoided. Exercises to strengthen the neck, shoulder, arm and upper back should be prescribed later. The investigators carrying out the Survey of Football Fatalities urged proper conditioning exercises to strengthen the neck and called for strict enforcement of rules prohibiting the practice of "spearing." What is needed most is the willingness on the part of the player to complain about his injury, as courage and competitiveness often makes a physician's job more difficult.

References

1. Football-Linked Deaths Found to have Decreased 36% in '69: *Medical Tribune Report*, July 1970.
2. Chrisman, O. Donald, et al: Lateral Flexion Neck Injuries in Athletic Competition, *JAMA*, 192: 7: 117-119 (May 17) 1965.
3. Nerve Wracking Impact of a Hard Tackle: *Medical World News*, January 27, 1967.



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Simultaneous Occurrence Of Streptococcal Pharyngitis And Infectious Mononucleosis

B. Cecil Gibson, B.S. and P. Raphael Caffrey, M.D.

Lexington, Kentucky

In a significant number of patients with infectious mononucleosis, throat cultures revealed the presence of hemolytic streptococcus. The clinician should consider the possibility of such combined infection when evaluating the patient with infectious mononucleosis.

ALTHOUGH infectious mononucleosis is frequently accompanied by a sore throat, only occasionally is there mention of the possibility of the simultaneous occurrence of infectious mononucleosis and streptococcal pharyngitis.

Evans, in a complete study of more than 500 University of Wisconsin students, noted that 10 per cent of 147 patients with infectious mononucleosis also had streptococcal sore throat. He felt that the streptococci were secondary invaders of the damaged tissue.[1]

During an eighteen month period, we became aware of an occasional simultaneous association of infectious mononucleosis and streptococcal pharyngitis. We believe this association may be of some clinical importance and are therefore reporting our findings.

Methods and Materials

Classically, in the Paul-Bunnell test for heterophile antibodies in infectious mononucleosis the antibody is demonstrated by titrating patients serum mixed with sheep cells and examining for agglutination. Differential absorption studies using beef erythrocytes and guinea pig kidney complete this time consuming procedure. This laboratory test has recently been modified to provide the same data by the use of a rapid differential slide test.* Sheep erythrocyte antigen, beef antigen and guinea pig antigen make it possible to perform the differential procedure.[2] This rapid screening procedure to check for the presence of infectious mononucleosis antibodies was done on patients referred to this laboratory.

Sheep blood agar plates were streaked with material from the patients' throats. Separation of *Streptococcus pyogenes* (Lancefield Group A) from other Lancefield types was done by using Bacitracin disks[3] as well as the standard fluorescent antibody technique.[4]

Results

During an 18 month period from January 1969 to June 1970 *Streptococcus Pyogenes* (Lancefield Group A) was isolated from 49 patients studied by this laboratory. Coincidentally 13 of these same patients were also screened for heterophile antibodies. Of these 13, six had a positive test.

Discussion

Davidsohn estimates some 60 per cent of the infectious mononucleosis patients have pharyngitis.[5] Considering this information along with our data, we believe that all patients suspected or proven to have infectious mononucleosis should also have a throat culture in order to rule out complicating streptococcal pharyngitis. The small study reported here indicates that almost half of the patients with infectious mononucleosis on whom throat cultures were done, also had *Streptcoccus pyogenes* (Lancefield Group A).

Conclusion

Although both a serological test for infectious mononucleosis and a throat culture were ordered in only a small percentage of the patients, the apparently high incidence of streptococcal pharyngitis in infectious mononucleosis patients noted in this study, would seem to warrant further consideration by the physician.

(Continued on Page 692)

*Monosticon. Organon Inc., West Orange, New Jersey.

Retroperitoneal Liposarcoma

A. J. Fernandez, M.D.* and Harold Redd, M.D.**

Hazard, Kentucky

Retroperitoneal liposarcoma is such a rare disease that few pathologists have had access to enough cases to form significant conclusions, but any case with a complete follow-up is worth mentioning.

Although definite advances have been made, despite the rareness of the disease, from the clinico-pathological point of view, very little has been gained from the therapeutic approach, and complete surgical removal, whenever possible, continues to be the only hope for cure of this type of neoplasm.

Although liposarcomas in general are considered the most common malignancies of soft tissue, very few pathologists have the opportunity to study many cases.

Because of the infrequent occurrence of liposarcomas, new observations are always worth mentioning, ie, facets of clinical behavior and treatment, in order to compare our results with those who are more familiar with these cases. In our review of the literature, we found that Pack and Pierson[6] have reported the largest number of malignancies of fatty tissue (105 cases), followed by Enzinger and Winslow[2] (103 cases), and Stout[8] (41 cases). These authors give an extensive study of this rare tumor from the clinico-pathological point of view and Stout has outlined the classification.

This paper deals with a retroperitoneal liposarcoma, the second most frequent location for a malignancy of fatty tissue. Because the initial symptoms are referred to neighboring organs and the abdominal mass is not palpable until the tumor has enlarged considerably, this type of malignancy in that particular location is probably one of the least responsive to treatment.

Late diagnosis is the rule and most of the time it is established at the operating table. This was true of the patient here reported, and despite the operative procedure, the tumor recurred in a very short period of time.

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Case Report

This case report involves a 62-year-old white male admitted 3-17-68 complaining of nausea, vomiting and abdominal pain of one-week duration. The symptoms were intermittent and were also associated with indigestion, distension and constipation. The abdominal pain was described as cramps in the mid abdomen. Three months before admission he passed some blood in his stool during an episode of abdominal cramps, anorexia and distension. Since this episode he had lost 10-15 pounds in weight. His past history was not remarkable except that he was a coal miner, had chronic bronchitis and some prostatic trouble.

Physical examination revealed a thin, pale white male in no acute distress. His temperature was 99.6, pulse 96 and B/P 120/60. The positive physical findings revealed an emphysematous chest and a firm, rounded, somewhat fixed mass in the right side of the abdomen. It was slightly tender and no guarding, rebound or tenderness was elicited. The mass was not palpable per rectum.

Lab. data included: C.B.C. 10.4 gr., Hg. Hematocrit 32., W.B.C. 9,000, 62 Segs., 2 Stabs, 23 Lymphs, 7 monos and 6 eosinophils. Urinalysis shows s.g. 1.012, neg. alb. and sugar, 2 to 3 W.B.C. VDRL—non-reactive. Gastric analysis showed total acidity 77, free HCL 46. Blood chemistry showed BUN 14 mg% and Glucose 113 mg. Bone marrow was hyperplastic. Blood in the stool was reported as negative. Bence Jones Protein was neg. Prothrombin time was 18 seconds and EKG was normal.

X-ray data: X-ray of the sinuses showed a right antral mucocele. I.V.P. was reported as normal on the right; there was fair visualization on the left. Barium enema was normal. Chest x-ray showed emphysema and minimal

arteriosclerosis of the aorta. G. I. series showed no upper G. I. Tract pathology. Rectosigmoidoscopy study done the day after admission was normal. On 4-1-68 the patient was subjected to an exploratory laporatomy and the surgeon found a somewhat rounded, firm, multilobular, apparently encapsulated, pale yellow retroperitoneal neoplasm measuring 19 x 17 x 7 cm. A portion of the terminal ileum and mesentery were spread over the tumor. Through blunt and sharp dissection the impression was that a complete removal of the tumor was accomplished. The kidneys appeared normal to palpation, and careful exploration failed to demonstrate any other pathology present in the abdominal cavity. The patient's immediate postoperative condition was satisfactory.

Microscopically the tumor was composed of a highly vascular meshwork of pleomorphic cells and frequent bizarre mono and multinucleated giant cells with a myxoid background. The pathologic diagnosis was poorly differentiated myxoid lyposarcoma (Fig. 1).

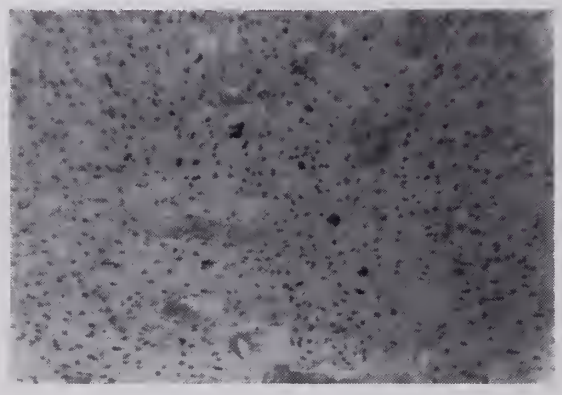


Fig. No. 1 (10X) shows a highly vascularized meshwork of pleamorphic cells with a myxoid background.

Except for clear discharge from the drain that was placed in the retroperitoneal area, the postoperative period continued uneventfully and the patient was dismissed on 4-12-68.

On 10-13-68, six months later, the patient was readmitted because of marked vomiting, nausea and cramps. Two weeks before he complained of progressive nausea, vomiting and increasing abdominal pain. At this time, on physical examination of the abdomen a rather large periumbilical mass was palpable. Chest x-ray was negative and abdomen x-ray

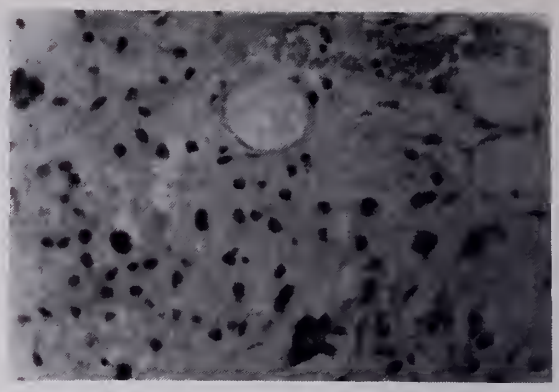


Fig. No. 1 (43X) Higher magnification, note bizaree mononuclear lipablast.

decubitus and upright views showed a midline soft tissue mass, somewhat ill-defined as to its borders which tended to displace the colon much in the same manner as an enlarged uterus would displace it. (Fig. 2) Prior to the second admission, a consultation with the University of Kentucky College of Medicine, departments of radiology and surgery was done.[3] The consensus of opinion was that cobalt therapy or radiation had no effect on this type of tumor and chemotherapy had nothing to offer.

With the diagnosis of recurrent retroperitoneal liposarcoma with intestinal obstruction, patient was operated on again, 10-17-68. At this time the surgeon reported recurrence of the retroperitoneal neoplasm with same gross characteristic. However, the lower portion extended down along the right lumbar gutter into the pelvis. The tumor was found to be adherent to the inferior vena cava and the external iliac artery, as well as the right ureter, which was freed and retracted laterally out of the way of the dissection. Most of the tumor was removed and adhesions of the

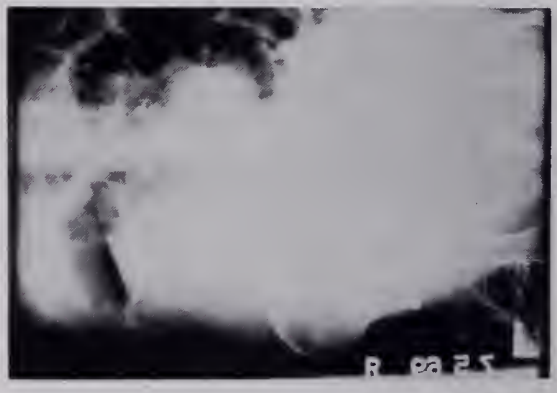


Fig. No. 2 Large soft tissue mass in the midline, displacing the colon.

small bowel were lysed. No other foci of tumor were identified, neither serosal nor visceral. The patient's postoperative period was unremarkable.

His third admission was on 3-18-69, with identical clinical symptomatology of previous admissions and a recurrent hard mass at the area of the umbilicus. In a palliative attempt to relieve the patient's symptoms a third surgical intervention yielded tumor recurrence. This time, resection of terminal ileum was necessary and again no sign of metastatic spread could be elicited. This patient had uneventful postoperative recoveries and, apparently improved, was dismissed 5-2-69.

From then on the patient underwent a downhill course. With symptoms of chronic intestinal obstruction, and later a recurrent mass in the mid abdomen, his general condition deteriorated rapidly. The final chest x-ray on 3-5-69 was reported as essentially normal and abdomen decubitus and upright views revealed extensive recurrent tumor in the right side of the abdomen with some associated ascites.

The patient's demise occurred on 9-16-69 and autopsy was refused.

Discussion

It is generally agreed that the retroperitoneal space is the second most frequent location of liposarcomas. The largest number originate in the lower extremities, where an amputation offers the patient considerable hope of permanent cure. This is not the case in the retroperitoneum, where the tumor goes undetected for a longer period of time, and, consequently, when treatment is administered to the patient, the disease has reached an advanced stage. The size of the neoplasm, adhesions and infiltration to neighboring organs makes it almost impossible to achieve complete removal at the time of the operation.

According to Stout's classification proposed in 1944,[8] our case corresponds to a poorly differentiated myxoid liposarcoma. The presenting symptoms were those of the gastrointestinal tract, pain and abdominal mass. After surgery recurrent abdominal mass with subacute intestinal obstruction was apparently due to direct tumor extension. After the initial surgical procedure, survival time was 17 months. Four months elapsed from first symptoms to surgical exploration. The diagnosis was not suspected and it was established at the time of surgery.

Neither clinical nor radiological evidences of metastases could be demonstrated. Despite initial and subsequent interventions it is generally believed that these neoplasms should be handled with extreme caution because of the possibility of metastatic spread by slight trauma.

After first removal of the tumor, the period of quiescence described by Ackerman and Wheeler[1] was very short, lasting only six months. From the histologic point of view, the cellular reaction composed of lymphocytes and plasmacytes in peritumoral or perivascular distribution and interpreted as host resistance associated with long survival was lacking. On the contrary, in multiple sections observed, areas of fibroblastic pattern in the recurrence as described by Holtz[4] heralded a much more rapid course (Fig. 3). The last specimen

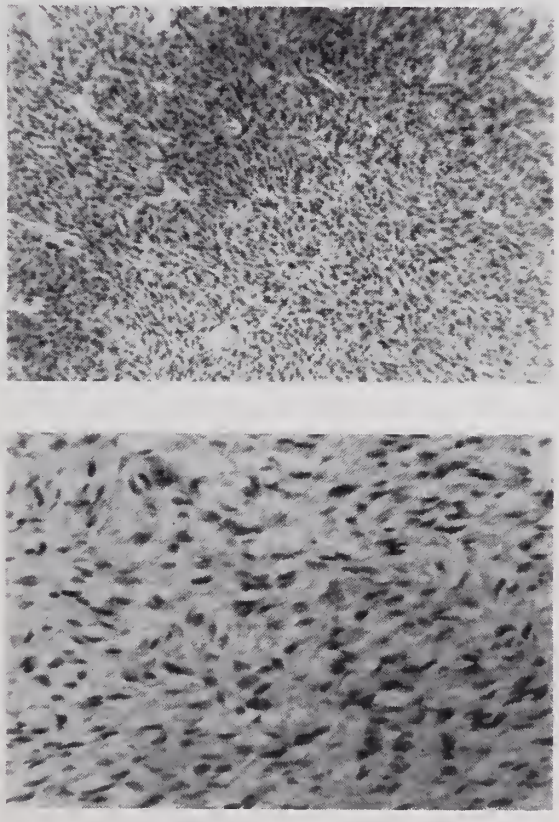


Fig. No. 3 (10X and 43X) Low and higher magnification of fibroblastic areas observed in the second surgical specimen.

examined showed extensive areas of necrosis and heavy inflammatory infiltration (Fig. 4). Death was attributed to secondary sepsis.

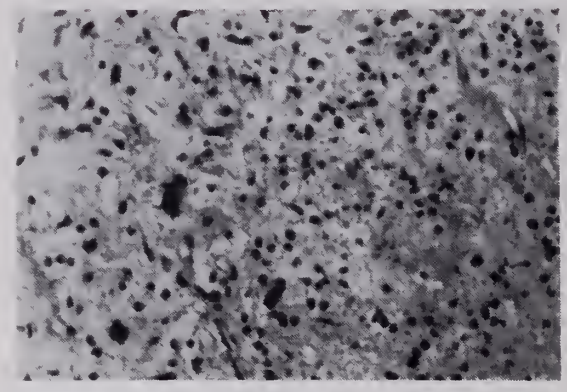


Fig. No. 4 (43X) Corresponds to the tumor recurrence before the patient's death and shows necrosis and inflammatory infiltrate.

Definite advancement has been achieved in the clinical and pathological aspects of this disease. Unfortunately, little progress has been made in reference to treatment. Wide surgical excision, whenever possible, is the treatment of choice. The use of radiotherapy is controversial. Some advocate extreme radiosensitivity with cases of permanent cures and long survival; others deny any beneficial effect, as Moreland and McNamara[5] who treated some of his nine cases with x-ray without satisfactory results. In Phelan and Perez-Mesa[7] surgery was the only treatment received in a series of 15 of their patients and results were similar to our observation; short quiescent postoperative periods and short survivals. Apparently some tumors with a richly vascularized stroma respond to radiologic treatment better than those with a more fibroblastic component. We do not pretend, with a single observation, to establish criteria for treatment of liposarcomas. However, in view of different results obtained by other authors, we feel inclined to its use in future cases and give to the patient at least the benefit of the doubt.

Summary

Retroperitoneal liposarcoma is a very rare neoplasm. We have presented a case in a 62-year-old Caucasian male who survived 21 months from initial symptoms and 17 months from the time of the initial operation. Its clinical behavior conformed to that reported by those who have had the opportunity to observe numerous cases.

There were neither clinical nor radiological evidences of metastases in the 17 months period of observation, despite three surgical procedures. From the histologic point of view there was no initial cellular response (host resistance), and fibroblastic areas were present in the recurrences (accelerated course). Inflammation of the recurrence occurred as a terminal event.

Radiotherapy and anti-cancer drugs were not recommended in our case. However, other authors have pointed out radiosensitivity, and have reported permanent cures.

From our review of the literature, we conclude that radiotherapy response is unpredictable. Considering the rapid course of the process in our patient with a short quiescent postoperative period of time, as well as the same results reported by others in patients subjected to surgical treatment only, we will be inclined in future observations to suggest x-ray treatment regardless of surgery performed.

Acknowledgement

Acknowledgement to Mr. Alfred Broadhead for his assistance in the microphotography of this case.

References

1. Ackerman, L. V. and Wheeler, P. *Southern Medical Journal*, 35:156, 1942.

2. Enzinger, F. M., and Winslow, D. J.: Liposarcoma a study of 103 cases Virchow *Arch. Pathology Anat.* 335:367-388, 1962.

3. Ward Griffen, University of Kentucky, School of Medicine Personal Communication.

4. Holtz, F., M.D. Liposarcomas—*Cancer*—Vol. 11:1103, 1958.

5. Moreland, R. B., and W. L. McNamara: Liposarcoma report of nine cases. *Archives of Surgery* 45:164, 1942.

6. Pack, G. T., and Pierson, J. C. Liposarcoma, Study of 105 cases. *Surgery* 36:687-712, 1954.

7. John T. Phelan, M.D. and Carlos Perez-Mesa M.D.—*Surgery Gynecology and Obstetrics* 115:609, 1962.

8. Stout, A. P. Liposarcoma—Malignant tumor of lipoblasts *Ann. Surgery* 119:86-107, 1944.



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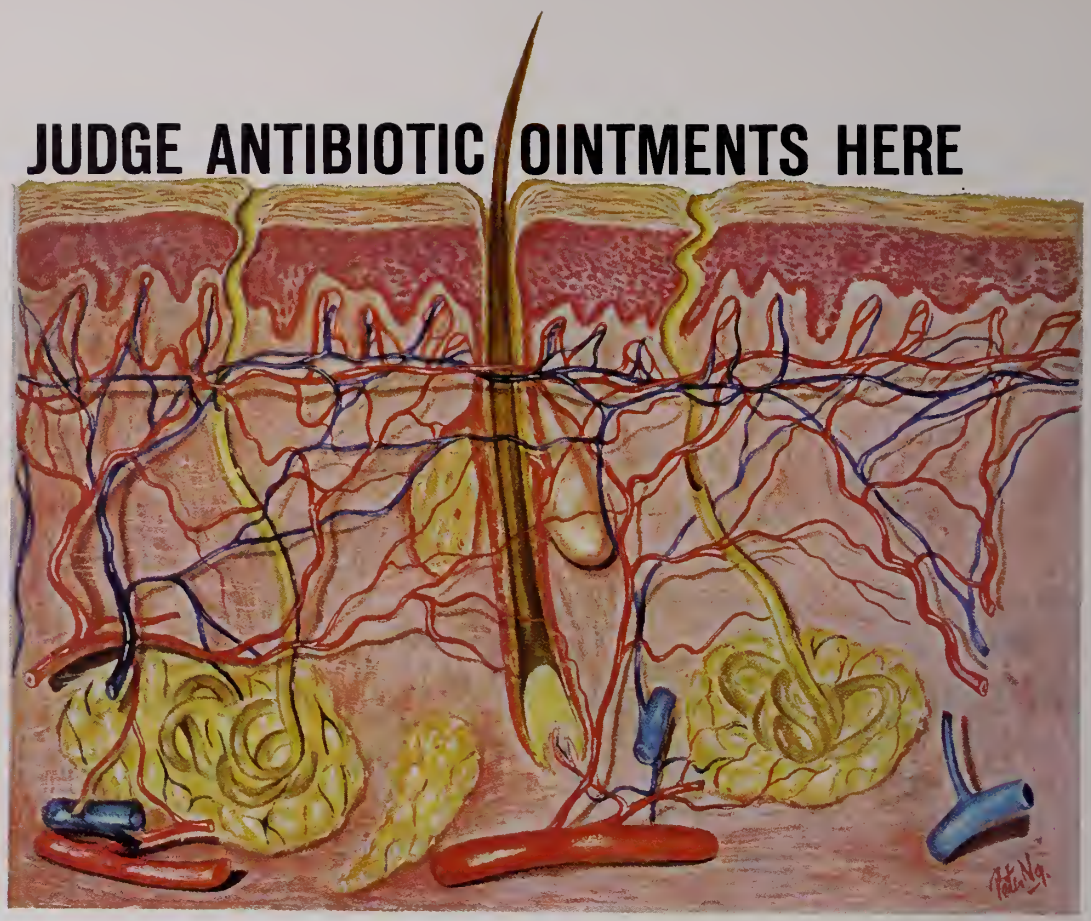
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SPECIAL ARTICLES

Cholera In The New World†

ABRAHAM M. GORDON, M.D.

"A Cholera Pandemic, caused by Vibrio cholera biotype El Tor, has spread from its endemic focus . . . . Southeast and South Asia have been affected and even now the Middle East is threatened . . . . there is great concern about further extension." These chilling words appeared in the July, 1968 issue of the *Annals of Internal Medicine*, describing a Cholera Pandemic that began in 1960 and for eight years has now devastated certain areas of the Far East. Cholera to this day remains a clear and present danger in some parts of the world.

Cholera has existed in India since earliest times. Known to the natives as Morshi, Mondeshin and Visuchika, Europeans call the disease Cholera; some prefer Asiatic Cholera, while others call it Indian Cholera.

Vague references to Cholera are found among the Greeks of the 5th Century B.C., such as Thucydides, Book 11. Hippocrates used a word which translated means "a flow of bile" and it is believed by some to be Indian Cholera. Since bile is absent from the rice water stools of Cholera victims, it would seem doubtful that Hippocrates was describing this disease. Yet military adventures during the Graeco-Roman period penetrated deep into the Asian Continent. Cholera may have been brought to the Mediterranean World by returning veterans or captured slaves, transported from their home in Asia. The ancient world was convulsed from time to time by severe epidemics and Cholera may have occurred among other pestilences at that time. The Old Testament describes several instances of epidemic disease.

In Second Kings (19:35) it is written, "And it came to pass that night that the angel of the Lord went forth, and smote the camp of the Assyrians a hundred fourscore and five thousand; and when the men arose early in the morning, behold they were all dead corpses."

Zechariah, Prophet of Israel, (14:12-14) speaks of a plague:

"Their flesh shall consume away while they stand upon their feet
And their eyes shall consume away in their sockets
And their tongue shall consume away in their mouth."

Epidemic Cholera is conceivable in both of these epidemics as recorded in the Old Testament. Cholera victims succumb quickly, usually in six to 48 hours after the onset of symptoms.

Traffic and trade grew astronomically between East and West by the late 18th Century and this greatly expanded commerce brought Cholera to remote areas, previously untouched by the disease. Terror and death became commonplace to millions during the 19th Century. No continent was spared, not even the thinly populated continents of the New World.

The First Pandemic, 1817-1823

Appearing in the district of Behar, Cholera became widespread in India by the spring of 1817. Patna, Dacca and Calcutta were invaded that summer. In the winter the disease appeared to subside only to reappear the following March. By the end of 1818 all of India was infected. The following year Ceylon, Burma, Sumatra and Singapore were stricken. East Africa and the Philippines did not escape. In 1820 the Chinese Empire was invaded. Japan was soon to follow. By 1821 Muscat, Syria, Palestine and South Russia were stricken with Cholera. In 1823 the disease disappeared. Europe had been spared. America had been left untouched.

The Second Pandemic, 1826-1837

Appearing first in Bengal, Cholera spread along the Ganges and soon all of India was covered. By 1828 Teheran was infected. In due course Cholera appeared in those Russian provinces bordering Persia. In the year 1831 all major Russian cities were stricken. Moving westward, Germany, Austria and Great Britain were soon infected. At this same time, pilgrims returning home from Mecca carried the disease to Turkey, Egypt, Morroco and Algeria.

In 1932 Cholera appeared in the New World. Irish immigrants arriving in Canada spread the disease along the St. Lawrence. New York City, invaded from the north by Cholera, was at the same time admitting immigrants from European ports with the disease. Cholera Hospitals appeared in all major coastal American cities. Mortality among physicians was high. In the population at large the mortality varied from one-twentieth to one-third, depending on the severity of the infection in different geographic areas. In New York City, with its population of 200,000 in 1832, more than 70,000 fled carrying Cholera into the interior. The poor and desolate were severely stricken. Many distinguished persons also

†*Lecture presented in Siena, Italy, September, 1968.*

lost their lives. During the summer of 1832 New York was a deserted city.

Treatment was rudimentary: one dram of bicarbonate of soda mixed with two drams of sodium chloride and given parenterally in six pints of water. Favorable results were reported after 20-30 ounces of this infusion was given.

Pennsylvania, Maryland, Virginia and Kentucky were soon struck down by the pestilence. In October of 1832 New Orleans was invaded followed by its rapid spread into the Mississippi River Valley. Ameliorating during the winter, the spring of 1833 produced a more vigorous attack. Halifax and Nova Scotia fell in 1834. In 1835 the disease reappreared in New Orleans. In that same year Mexico was invaded at Vera Cruz and Tampico. Cuba soon followed as did many of the port cities on the northeastern coast of South America. In 1837 Central America was infected. Finally after 11 long years of devastation Cholera disappeared leaving death, terror and fear in its wake.

The Third Pandemic, 1846-1863

In 1840 Cholera had become widely disseminated in India. The disease quickly spread to the Philippines and China and by 1846 was again in Persia. By 1848 Cholera was in England. All of Europe had by this time become infected.

In 1848 Cholera appeared in New Orleans and simultaneously in New York City. Within months all of the United States east of the Rocky Mountains was infected. In April, 1848 Cholera was again in Canada, brought by immigrant ships from European ports. In the western United States all the great river valleys of California including the San Jose, San Joaquin and Sacramento were infected.

In 1849 the sickness again appeared in Mexico, first from Texas through the border town of Matamoras and also from the seaports on the east coast. From Panama Cholera came to Acapulco and Mazatlon. In that same year all major Mexican cities were infected. In Central America only Panama suffered with the pestilence as the other small states in this area escaped. In the West Indies Cholera was severe. In 1850 Cuba and Jamaica reported Cholera and there the disease raged continuously for four years. The mortality rate was astonishing with tens of thousands of deaths. In 1851 it was Santo Domingo, followed by the Bahamas, Puerto Rico and many of the adjacent islands. In 1855 Venezuela became infected and Brazil soon followed. The disease lingered in many places only to disappear after 15 years, having brought death to millions. In two years Cholera would again journey from India to the West.

The Fourth Pandemic, 1865-1875

Beginning in the lower basin of the Ganges, Cholera spread over all of India. The disease appeared in Mecca among the faithful, having been brought to this city by Indian pilgrims. The outbreak signalled panic to the Moslems and general flight resulted. Cholera soon appeared in Suez brought by a vessel carrying pilgrims from Jeddah. All of Egypt was soon invaded. Other pilgrims returning to their homes in North Africa carried Cholera to their cities and villages. From these places southern Europe received the pestilence and the infection spread.

In the Western Hemisphere Guadeloupe was the first to report Cholera. Martinique, San Domingo, Cuba and St. Thomas soon followed. In 1966 Cholera appeared in New York, New Orleans and Nova Scotia. Philadelphia and Baltimore were soon invaded. From New Orleans again the disease spread quickly into the interior. Central America received the disease from infected vessels that had made port in New Orleans. For the first time Cholera appeared in the West Coast of South America in 1866. It continued to ebb and flow, disappearing and reappearing in infected areas until 1875. Since 1875 the United States has been free of epidemic Cholera.

Cholera Since 1875

In 1879 the so-called Fifth Pandemic appeared in India and in four years reached Europe. It was during this pandemic that Koch, working in Egypt discovered the Vibrio comma and later travelling to India confirmed the etiology of the disease.

In 1891 another serious outbreak of Cholera occurred in India and appeared in Europe the following year. One million deaths occurred in Russia alone, including Peter Iljitsch Tschaikowsky, the noted composer, who died of Cholera on November 6, 1893, at St. Petersburg. It was during this epidemic that Cholera appeared in Hamburg and from the careful studies made in the Hamburg epidemic the transmission of Cholera was finally understood.

The so-called Sixth Pandemic appeared in 1902 and spread over India, China and the Philippines. It again appeared in Russia with many deaths. In the more advanced countries of the world the lesson of Hamburg had not been lost and Chlorea did not spread as in former times.

In 1913 Cholera was present among troops engaged in the Balkan War. During the First World War small outbreaks of Cholera occurred in the troops of Germany, Austria and Italy. Among Russian Prisoners of War the disease was found in 18 men held in Berlin. Since 1923 no cases of Cholera have appeared in Western Europe. Russia and especially the Ukraine have had repeated outbreaks.

Conclusion

My interest in Cholera dates back to 1941. In New Orleans I encountered my first (and last) patient with the disease. Unfortunately the Second World War intervened and this interesting case report went unpublished. Briefly, the patient was a longshoreman, employed that day in unloading a cargo of lumber brought from the Philippines. At lunch time he shared his food with a member of the ships' crew. He was taken ill with diarrhea. Rice water stools appeared followed by rice water vomitus. Continuous bowel motion and loss of body fluids produced serious dehydration. Venous blood obtained by puncture was highly viscous. So-called "washer woman" skin changes were seen. The patient was cyanotic and shortly after admission went into shock. Intravenous fluids failed to revive our patient and death occurred

(Continued on Page 692)

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THE INSURANCE PAGE



Forces Of Change

All about us we see changes taking place in our environment and in our country. Some of these changes are expected and some are quite surprising. One of the more surprising changes for the writer was an article which appeared in the American Legion magazine, August, 1970.

The American Legion has generally been a right-wing conservative organization, yet the article "Better Medical Care at Less Cost is Possible," by Roul Tunley, suggests some far reaching socialistic changes for the country.

Mr. Tunley complains that the public has been patient with the doctor bills and high cost of medical care too long. However, he appears to have found the secret of better medical care at less cost in the proposed national compulsory health insurance with prepaid group practice medical plans. Mr. Tunley's description of the prepaid group practice concept is very simplified. He states, "The basic idea is simple. You pay your medical insurance premiums regularly to a medical group—and it then gives you whatever care you need. While there are all sorts of details, basically that's it."

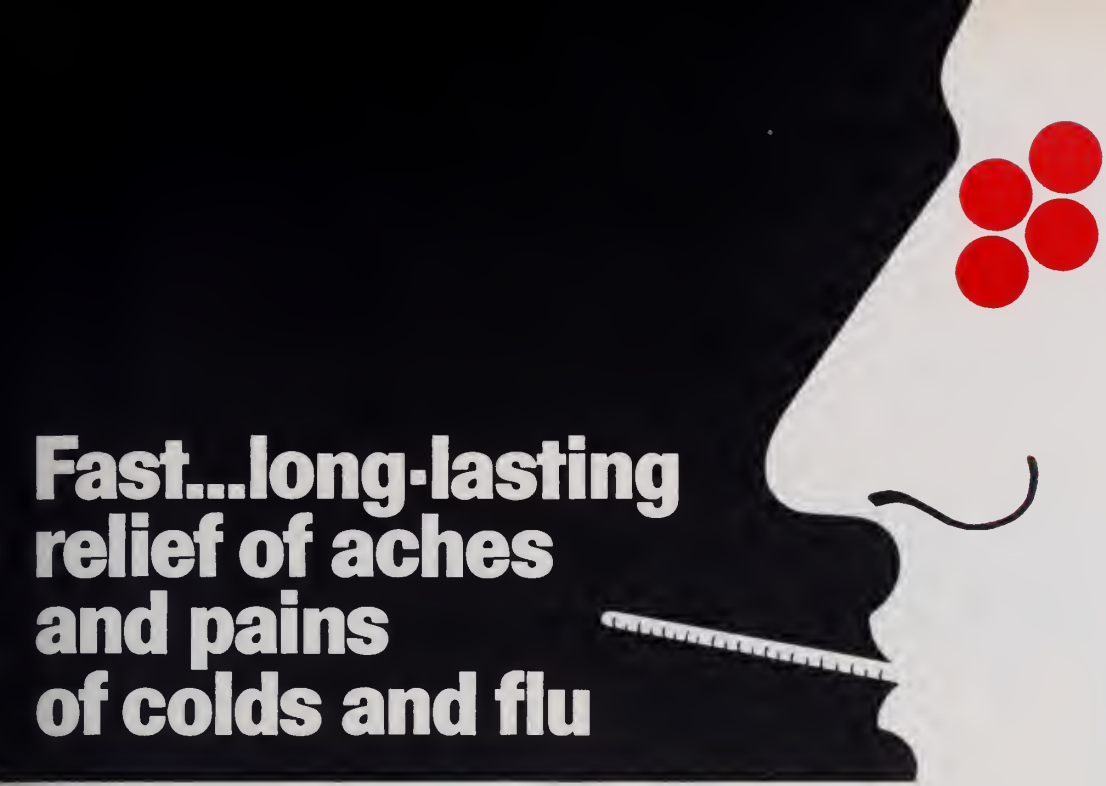
I have often heard of the small print in sales promotion materials, but this statement, "While there are all sorts of details," is the greatest joker this writer has ever seen. You can bet your last dollar that there are many details; and under compulsory health insurance, there will not only be a few details, there will be pages and pages and pages of regulations and restrictions.

Mr. Tunley goes on to list a number of the abuses of the present medical systems and a few of the blessings of prepaid group medical practice. He tends to soothe the medical profession by stating that there is nothing wrong with the doctors and that we have enough doctors at present to give medical care under the group practice system.

The present writer is astounded that the American Legion would present such an article in its magazine, and is even more astounded if the Legion believes this story. It is the opinion of your insurance editor that if the government is ever able to force the medical profession against its will into prepaid group practice plans under national health insurance, it will be able to force any group, profession, or industry, to do anything the socialistic planners desire. This plan is not just a plan to bring better medical care at less cost to the people; it is the plan for far-reaching socialistic regimentation which will do away with private insurance companies and private practice of medicine. It is the beginning of totalitarianism in the government and an end to the American dream.

Your insurance editor does not propose to know what is best for the country, but he does not believe it is national health insurance and socialistic regimentation.

LEWIS DICKINSON, M.D.



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Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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Available: Bottles of 12, 36 and 60 tablets.

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

OCTOBER

12 PANMED television series, "Dental Radiography," KETV-TV 10:30 p.m. EDT (9:30 p.m. CDT)

17 Annual Meeting, Kentucky Chapter, American College of Physicians.

17-18 Postgraduate course, "Clinical Demonstration of Common Skin Problems," University of Kentucky Medical Center, $30 fee

19 PANMED television series, "Organizing for Progress," KETV-TV 10:30 p.m. EDT (9:30 p.m. CDT)

23-24 Postgraduate course, "Listening, Deciding, Doing," University of Kentucky Medical Center, $60 fee

23-24 Fall Conference, Kentucky Thoracic Society, Boone Tavern Hotel, Berea

24 "Practical Cancer Chemotherapy," American Cancer Society, Kentucky Division, University of Kentucky Medical Center, Lexington

26 PANMED television series, "Oral Cancer," KETV-TV 10:30 p.m. EDT (9:30 p.m. CDT)

NOVEMBER

2 PANMED television series, "A Bright Future," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

5-6 Fourth Annual Newborn Symposium, University of Louisville School of Medicine, Louisville.

9 PANMED television series, "Utilization of Dental Auxiliaries," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

16 PANMED television series, "Clinical Pharmacy," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

23 PANMED television series, "The Anemic Patient," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

30 PANMED television series, "The Nurse and the Unwed Mother," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

DECEMBER

7 PANMED television series, "Diagnosis and Treatment of Endodontic Emergencies," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

14 PANMED television series, "Students Look at Drug Abuse," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

18-19 Postgraduate course, "Practical Ophthalmology for the Primary Physician," University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

OCTOBER

12-16 Clinical Congress of American College of Surgeons, the Conrad Hilton Hotel, Chicago, Ill.

14-16 Cleveland Course in Pulmonary Disease, St. Luke's Hospital, Cleveland.

25-29 Fall Scientific Assembly, American College of Chest Physicians, Century Plaza Hotel, Los Angeles.

NOVEMBER

6-8 Congress of County Medical Societies, Annual Convention, Netherland Hilton Hotel, Cincinnati

11-12 Postgraduate course, "Diagnostic Procedures in Gastroenterology," Cleveland Clinic Educational Foundation, Cleveland

16-19 Annual Meeting, Southern Medical Association, Dallas

29-Dec. 2 Clinical Convention, American Medical Association, Boston

DECEMBER

9-10 Postgraduate course, "Current Concepts in Opthalmology," Cleveland Clinic Educational Foundation, Cleveland

JANUARY

7-9 National Conference on Cancer of the Colon and Rectum, Hotel del Coronado, San Diego, Calif.

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can to avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Ephraim McDowell Drive, Louisville, Ky. 40205.

The actions of the official Tincture and Extract of Belladonna result chiefly from their Atropine content . . . conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



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Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.



Each tablet or capsule contains: Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

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Caution: Federal law prohibits dispensing without prescription.

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Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

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Roche announces

Efudex®

(fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex®(fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

2/2/68—After 11 days of treatment. Erythema is seen at site of keratoses. In addition, numerous lesions not apparent prior to therapy have become manifest by sharply defined reactions. Intervening skin, also treated, shows no response to therapy.

2/19/69—One year after cessation of therapy. Skin appears clear with no evidence of scarring. Examination reveals lack of recurrence or the formation of new lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new Efudex® (fluorouracil) cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning the site of application. Other local reactions included dermatit scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scalin swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice da with a nonmetal applicator or suitable glove in an amount of t solution or cream sufficient to cover the lesion. When Efudex i applied to a lesion, a response occurs with the following seque erythema, usually followed by vesiculation, erosion, ulceration necrosis and epithelization. The lower frequency and intensity activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammator reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of th lesion may not be evident for 1 to 2 months following cessation Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—contain g 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methy and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions wh complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or mo was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 17 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2' solution when large areas were to be treated. Approximately 30' of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

ROCHE Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

EDITORIALS

Men Of Letters

WITH this issue we at *The Journal* present what we hope will evolve into a regular and continuing feature—Letters to the Editor.

In our complicated world of medicine today, many issues, of both science and socio-economics, seem to cry out for the comments and the guidance of knowledgeable physicians. It will be, as usual, the aim of this *Journal* to offer information, education, and stimulation to all of the widespread doctors in Kentucky; it will be of value though, we believe, for these pages also to provide ventilation—a forum for the interchange of ideas among these same widespread and hard-working men. Only once a year, during our (recently completed) Annual KMA Meeting, do we have a reasonable chance to compare with our professional brethren throughout Kentucky our interesting cases, our clinical hunches, our views of medical education and medical economics, etc. With the institution of this "Letters" feature, you will have constantly available, whatever your points of view, a sympathetic ear here on the Editorial Board, and, within reasonable limits, we will publish monthly all correspondence of interest.

From time to time we will present, in addition to our usual editorials (which we hope will touch upon topics you find pert and pertinent), articles by men who in their fields of special interest have information or opinions which seem to us worthy of publication. One such article, by Doctor Ed Fadell, inaugurates our "Point of View" column in this issue. Your comments in regard to his article, to this editorial policy, to any aspect of any scientific article or KMA organizational notes contained in this *Journal,* will be welcomed. This Journal exists for you, its members, and if you want an idea of yours to be heard, we want to help you accomplish just that.

Many of our own members, we know, are concerned about the place of a state medical journal in today's medical practice. This Editorial Board feels strongly that there is a very real and valuable place for this *Journal,* in helping to draw together the physicians in this state, and we feel that all of us in KMA can be more effective if information and intercommunication are fostered through these pages. Write!

WALTER I. HUME JR., *M.D.*

Today's Physician's Assistants

OF the millions of words that have recently appeared on "the physician's assistant", 99 per cent have concerned the new assistant who is being programmed to solve all problems in the future. Only the briefest nod has been accorded the assistants who now share our over-work and fatigue.

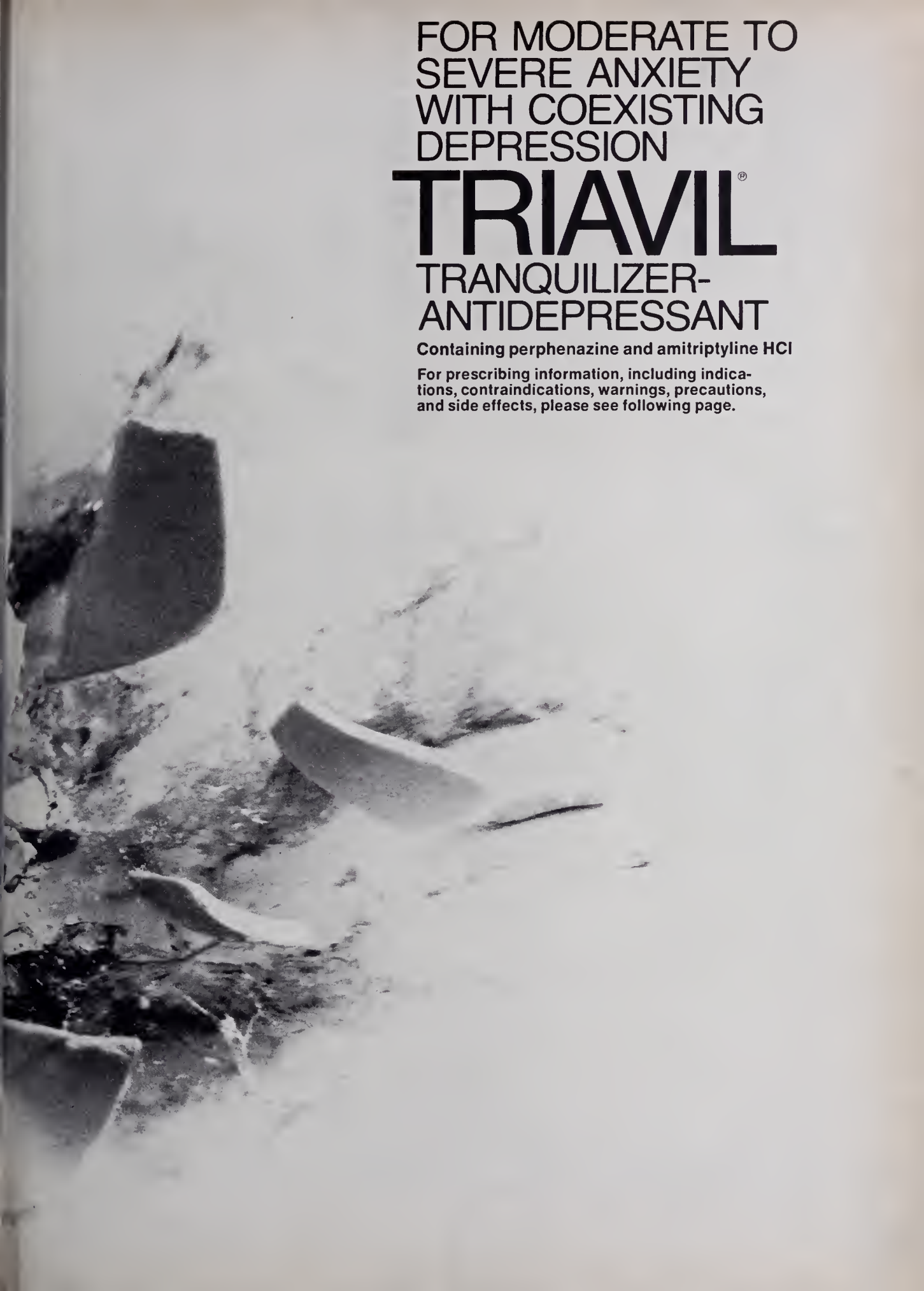
Recently, the American Society of Clinical Pathologists forwarded an engraved plaque attesting that the physician "and Staff" were active participants in continuing education in clinical pathology. Gleaming from the wall of her cubicle, this had a most heartening effect on the young lady who runs the control specimens and calculates and plots the standard deviations that constitute the tedium of the quality control program.

Reviewing the office roster shows a number of other assistants who deserve some morale-boosting recognition. Presumably their official Associations could devise a system of recognition for our RN's and LPN's. Some secretaries, and some of the typists in Medical Records at the hospitals deserve a quality control award. This would recognize those with least misspellings and over-strikes as they decode our mumbling and uneven dictation into a semblance of the King's English.

(Continued on Page 686)

BREAKUP—symbol of the impact of emotional stress. But when the stress exceeds transient rage or depression—and settles into a chronic mixed anxiety depression state—combined tranquilizer-antidepressant therapy could be indicated.





FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.

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TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; pregnancy; and in patients with known hypersensitivity to phenothiazines or amitriptyline. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least two weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response. Do not give concomitantly with guanethidine or similarly acting compounds since it may block the antihypertensive effect.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be increased.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Use with caution in patients with glaucoma and those with problems of urinary retention. Perphenazine can lower the convulsive threshold in susceptible individuals. It should be given with caution to patients with convulsive disorders. Dosage of the anticonvulsive agent may have to be increased. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients who have previously exhibited severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation. Significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea excitement; hypertension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; impotence increased appetite and weight gain; allergic-type reactions manifested by skin rash, swelling of face and tongue itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, stomatitis blurring of vision, reversible dilatation of the urinary tract urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information, consult your MSD Representative or see the package circular. Merck Sharp & Dohme Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD MERCK SHARP & DOHME

Letters To The Editor

Dear Editor:

The July, 1970, issue of *The Journal* of the Kentucky Medical Association published an editorial by Doctor Sam A. Overstreet entitled, "Hospital Beds—We Need 'Em." The first five paragraphs of this editorial dealt with the utilization of existing acute hospital beds. There are several statements and conclusions in these paragraphs with which I vigorously disagree.

Dr. Overstreet quite correctly reported the findings of the one day hospital survey conducted by the Jefferson County Medical Society, under the excellent chairmanship of Doctor Charles Smith. This survey found that 7.3 per cent of all patients reviewed on that day were not in need of any type of hospital care. In addition, there were 15.5 per cent that could be receiving their hospital care in a so-called minimal or self-care unit at a greatly reduced cost. Doctor Overstreet then stated, "it was concluded from this survey that there was not really a problem of gross over-utilization of hospital beds in this city." It is not clear to me whether Doctor Overstreet himself concluded that there was no over-utilization or whether this was the conclusion of the Jefferson County Medical Society's Survey Committee. To say that 22.8 per cent of all patients hospitalized on that particular day either did not need to be in the hospital or could be in a less costly type of facility was not gross over-utilization, I feel is a fallacious conclusion.

There are 3,072 acute hospital beds in the seven county area of the Falls Region Health Council, the great majority of which are in Jefferson County. Twenty-two and eight-tenths per cent represents roughly 600 acute beds that were improperly utilized on that day.

The estimated cost of building an acute hospital bed today ranges from a low figure (Extendicare's proposal for the St. Matthews Hospital) of $26,000 to (Methodist Evangelical Hospital's projected addition) of $64,000. The total cost, therefore, of 600 acute beds today would vary from 15.7 to 38.4 million dollars. In addition, the cost of operating an acute bed for one year is approximately half the construction cost. This is a very significant amount of money. Even applying this formula to just 7.3 per cent of the acute beds would represent a tremendous potential saving.

I believe, and I believe the Jefferson County Medical Society's survey lends support to the concept that we must strive in every way possible to alter our delivery of medical care so that we may provide better care to the most people with our available financial resources. The tenor of Doctor Overstreet's editorial implies to me that we do not have enough hospital beds. He states, "it is not likely that in any case a supply of beds will catch up with, not to mention overtake, the demand in the near future." Unless the medical profession approaches this problem with the desire to innovate and experiment with new approaches to the delivering of medical care, Doctor Overstreet's last statement will undoubtedly be true.

Stuart Graves, Jr., M.D.

EDITOR'S NOTE: The following letter is a reply to Doctor Graves by the author of the editorial, Doctor Overstreet.

Dear Doctor Graves:

The observations recorded in this article were entirely mine and not the conclusion of the Jefferson County Medical Society Survey Committee. However, I did submit the article to Doctor Charles Smith for review and approval before it was published. Doctor Smith made no objection or unfavorable comment to me before or since it was submitted for publication.

Your observations are very interesting and helpful and I have no great disagreement with the conclusions that you reach. To acquire a sufficient number of hospital accommodations for the type of use required, whether acute or otherwise, is a problem to which there is no immediate answer. I believe, however, that the physicians and agencies concerned with the solution of this will continue to work together more effectively.

Sam A. Overstreet, M.D.

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His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through *her* menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

Point Of View

In April 1970, Spindletop Research published the results of an evaluation of the performance of the Clinical Laboratory of the University of Kentucky Medical Center and made this evaluation available to hospital administrators throughout the State of Kentucky.[1] The evaluation was requested by the University Hospital Administrator and the Dean of the College of Medicine because it was felt that "in spite of the provision of additional resources, the operational performance of the laboratory has not kept pace with the demand for services." It was also "believed that an analysis by an independent organization would be helpful in meeting current and future problems."

The evaluation was apparently performed by a Mr. Brian Kiernan, and the report was approved by Mr. Theodore R. Broida, president of Spindletop Research. The qualifications of these two individuals, as regards their abilities to accurately assess the performance of the clinical laboratory on a professional basis, were not stated.

The main conclusion was that the operational performance of the laboratory had not kept pace with the increased demand for services.

The study utilized published material concerning laboratory operation as well as "by a visit to a private laboratory in a large metropolitan area." Evidently, on the spot comparison of the hospital laboratory operation with other university medical centers was not made. Adequate knowledge of operations in similar university-associated facilities would seem to be mandatory.

Great emphasis was placed on the revenue generating ability of the laboratory. Specifically, items related to surgical pathology and cytology were felt to have poor revenue-producing capability and hence, should be trimmed in staff resources. No statement was made concerning the effect this would have on patient care within the hospital. It is generally well known that in hospital operations the surgical pathology section does not generate sufficient revenue to cover its own operating expenses, and must be in turn subsidized from other laboratory procedures. However, it is generally well recognized that the service afforded to the patient by the surgical pathology section constitutes a critical function.

Further, the investigator suggests that the less frequently ordered laboratory tests are far too costly and generate too little revenue to justify their conduct within the laboratory. He suggests that these should be perhaps in part, parcelled out to local hospitals. No comment is made concerning the capability of the local hospitals to perform the more esoteric tests or their desirability to do them. If low or no revenue-producing esoteric laboratory methodologies are to be deleted, perhaps the hospital should investigate the possibility of deleting more complicated surgical and obstetrical procedures, in that these also tend to yield little revenue.

Criticism is made of the large number of tests per admission ordered. Certainly, such a criticism cannot be directed at the laboratory, but rather at the hospital staff. Further, it is stated that the laboratory should have "a manager" without qualifications as to background, salary, or specific duties. The only statement is that he should report to the pathologist. No mention is made of the role of the technologist or the chief medical technologist either in laboratory management or administration. One should be cognizant of the fact that the various medical technology groups are demanding more and more management and administrative say in conduct of the laboratory.

The utilization of the computer within the laboratory is criticized. It was felt that the

(Continued on Page 692)

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ORGANIZATION SECTION

Joe D. Miller Is Appointed Vice-President Of The AMA

Joe D. Miller, a native Kentuckian, was appointed assistant executive vice-president of the AMA at the Association's Board Meeting September 11-12. He will supervise the Divisions of Management Services, Communications, Public Affairs and Medical Practice in his new position.

Other organizational changes saw Richard S. Wilbur, M.D., former assistant executive vice-president, moved to the new position of deputy executive vice-president. Also named to one of the two new assistant vice-president positions was William R. Barclay, M.D.

Mr. Miller has worked for the medical profession since 1957, when he first joined the AMA. Born in Smith Grove, he is a graduate in business administration from the University of Kentucky.

His initial professional experience in the field of health was gained in Kentucky, where he served as executive director of the Kentucky Tuberculosis Hospital Commission from 1949-1957.

Mr. Miller joined AMA as a research associate specializing in matters relating to hospitals, nursing homes and other types of medical facilities. He later served as AMA field representative and then became executive director of the American Medical Political Action Committee (AMPAC). Mr. Miller was Director of The AMA Public Affairs Division preceding his new appointment.

Ky. Thoracic Society Conference To Feature Dr. Benjamin Felson

Benjamin Felson, M.D., professor and director, department of radiology, University of Cincinnati, is the headline speaker for the fall scientific session of the Kentucky Thoracic Society set for October 23 and 24 at Boone Tavern in Berea.

Dr. Felson will discuss "More Fundamentals of Chest Roetgenology" at the opening dinner meeting on Friday, October 23. He also will be a participant on a "Stump the Experts—Bring your Own Case" panel on Saturday, October 24. Other panelists for that session are: Ben V. Branscomb, M.D., professor, department of medicine, University of Alabama; and Richard B. McElvein, M.D., thoracic surgeon, Lexington.

Other sessions are planned on "Blastomycosis" by Ernest W. Chick, M.D., Lexington; "Dyspneic Miner and the Federal Black Lung Act of 1969" by Emery Lane, M.D., Louisville; "New Anti-Tuberculosis Drugs" by N. Alex Saliba, M.D., Louisville; and "Never Again — A Pike County TB Epidemic" by William P. McElwain, M.D., State Health Commissioner.

All physicians are invited to attend and further information is available from Kentucky TB and Respiratory Disease Association, 4100 Churchman Avenue, Louisville, Kentucky 40215.

PANMED Television Programs Scheduled For Fall Showing

A series of 11 continuing medical education programs are being presented in weekly broadcasts this fall over the Kentucky Educational Television Network, according to Thomas L. Heavern, Jr., M.D., Highland Heights, KMA-ETV committee chairman.

The PANMED series, which is being broadcast every Monday at 10:30 p.m. EST, is sponsored by the Kentucky Medical Association, the Kentucky Chapter of the American Cancer Society, the University of Kentucky Medical Center and the University of Louisville School of Medicine.

The first program, "Not Child, Not Adult: Adolescent Nursing" was shown October 5. Future programs in the series include "Oral Cancer," October 26 and "The Anemic Patient," November 23.

Check your local newspaper for the channel number of the KETV station nearest you.

Physician Participation Urged On Drug Education Committees

The importance of physical participation on the county drug education committees organized by the Department of Mental Health was recently discussed by the members of the KMA Executive Committee. Walter L. Cawood, M.D., Ashland, KMA president, complimented the Woman's Auxiliary for their activity in this field, but pointed out that more physicians should be working on the drug education committees.

The Department of Mental Health has organized county drug education committees in 105 Kentucky counties. Almost 100 interested citizens have attended regional training sessions to learn how to help meet their county's drug education needs.

Drug committees will soon be organized in the remaining 15 counties and intensive follow-up training will be done in all Kentucky counties. Dale H. Farabee, M. D., Commissioner of Mental Health, recently announced.

Interested physicians may inquire through the KMA Headquarters Office about the local committees.

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Direct and immediate cash savings — three an four times your membership fee — may be realize in a single business transaction.

Here's how you can get these remarkable benefi

Regular PSCA membership is open to incorporate professionals exclusively. Junior membership t qualified senior students, interns, residents an fellows. Dues for Regular membership are $2 for each stockholder-employee per year. $10 fc Junior members. Complete the coupon below an send it with your check today. You'll be provisio ally enrolled until qualification is approved. Ben fits of membership come just as easily as th means of joining. Full information covering a details will start you enjoying your chosen profe sion as never before.

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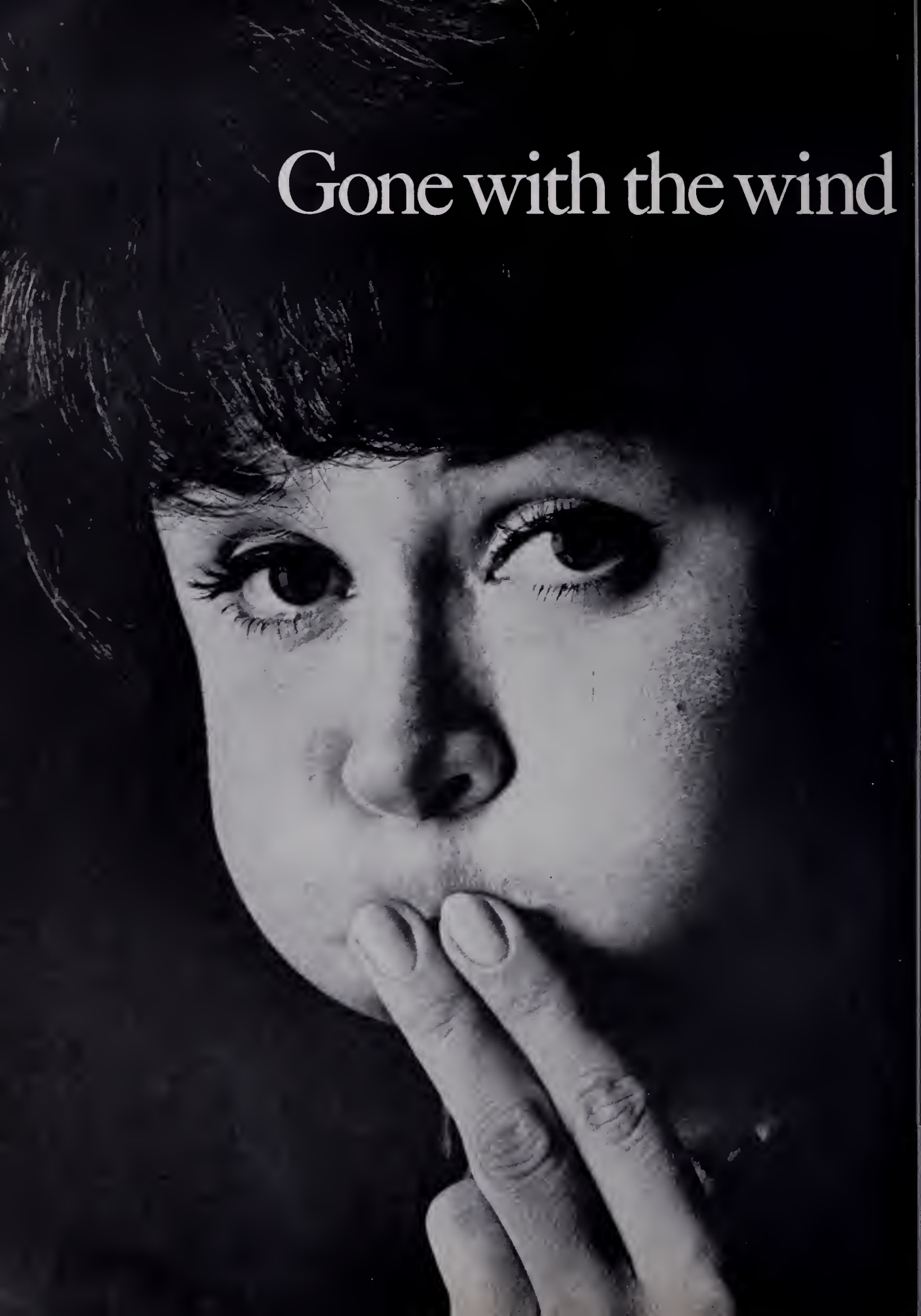
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(2) Samuel N. Workman, M.D.
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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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KENTUCKY THORACIC SOCIETY'S FALL CONFERENCE ON RESPIRATORY DISEASES

October 23-24

Boone Tavern Hotel — Berea, Kentucky

FRIDAY, OCTOBER 23

6:30 p.m. **Dinner**
Fundamentals of Chest Roentgenology
Ben Felson, M.D., Professor and Director
Department of Radiology
University of Cincinnati

SATURDAY, OCTOBER 24

Abram S. Benenson, M.D., Moderator
University of Kentucky

8:30-10:30 a.m. **Stump The Experts—Bring Your Own Case**
Panel: Ben V. Branscomb, M.D., Professor
Department of Medicine
University of Alabama
School of Medicine
Ben Felson, M.D., Chairman
Department of Radiology
Cincinnati General Hospital
Richard B. McElvein, M.D.
Thoracic Surgeon
Lexington

10:30-11:00 a.m. **Coffee Break**

11:00-11:20 a.m. **Blastomycosis**
Ernest W. Chick, M.D.
Professor of Community Medicine
University of Louisville
School of Medicine

11:30-11:50 a.m. **Dyspneic Miner and The Federal Black Lung Act of 1969**
Emery Lane, M.D.
Fellow In Pulmonary Disease
University of Louisville
School of Medicine

12:00-12:20 p.m. **New Anti-Tuberculosis Drugs**
N. Alex Saliba, M.D.
Medical Director
Hazelwood TB Hospital

12:30-12:50 p.m. **Never Again—A Pike County Tuberculosis Epidemic**
Wiliam P. McElwain, M.D.
State Health Commissioner

KENTUCKY THORACIC SOCIETY · 1954 ·

10 Minute Discussion periods follow each presentation

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KMA Telephone Number Changed

The telephone number of the Headquarters Office of the Kentucky Medical Association has been changed. Effective September 27, the new number is 452-6324. Please note that only the prefix has been changed from — 454 to 452. The headquarters staff urges you to make this change in your records.

Today's Physician's Assistants

(Continued from Page 669)

Blue Shield and Blue Cross might well use their computer *expertise* to suitably recognize the insurance clerks who submit a minimum of incorrect or rejected claims.

Above and beyond all others, should there not be a special gold star for those eager beavers who have mastered Medicare directions, regulations and instructions so well that an occasional patient receives prompt and adequate repayment for his receipt, on the first submission?

GEORGE F. BROCKMAN, M.D.

KAGP Seminar Planned October 21-22

The Kentucky Academy of General Practice will hold a seminar at Cumberland Falls State Park October 21-22, according to Donald C. Barton, M. D., and Frank R. Lemon, M. D., co-chairmen of the seminar.

Topics to be discussed include "Medical and Surgical Approaches to Certain G. I. Diseases," "Anemias," "The Medical-Surgical Approach to the Patient with Urinary Signs and Symptoms" and "Drug Abuse."

This program is acceptable for 12 accredited hours by the American Academy of General Practice. All physicians, including non-members of the Academy, are welcome to attend.

Cancer Course Offered

The Kentucky Division of the American Cancer Society is sponsoring a course entitled, "Practical Cancer Chemotherapy," on Saturday, October 24, 1970. The course will be held at the University of Kentucky Medical Center in the Hospital Auditorium.

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In Memoriam

PAUL A. KEENEY, M.D.
Louisville
1903 - 1970

Paul A. Keeney, director of medical education at SS. Mary & Elizabeth Hospital since 1964, died July 17 at the age of 67. Doctor Keeney, a native of Wilkes-Barre, Pa., was a surgeon and chief of public health and welfare in Seoul, Korea during a ten-year career with the U.S. Army. In 1956 he became director of Williamson Memorial Medical Center in Pike County, Ky.

ARCH D. KENNEDY
Louisville
1898 - 1970

Arch D. Kennedy, 72, a Louisville internist since 1917, died August 5. A native of Chattanooga, Doctor Kennedy graduated from the University of Tennessee Medical School in 1926. He was a life member of the American College of Physicians and the Southern Medical Association.

ROBERT L. RAINEY
Louisville
1931 - 1970

Robert L. Rainey, associate professor of medicine and chief of the cardiology section at the University of Louisville School of Medicine until July 1, died August 5. He was born in Brownsville, Tenn. and came to Louisville in 1967. He was a member of the American College of Physicians, the American Heart Association, the Kentucky Heart Association and the Society of University Professors.

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KMA Sets Membership Record

A record number of physicians have joined the Kentucky Medical Association, according to the membership department. The membership report notes that there are, as of September 1, 2432 active members as compared to 2419 for the period ending December 31, 1969.

In order to establish accurate membership figures, county medical society secretaries are urged to submit all names of new members to the Headquarters Office at their earliest convenience.

County Societies To Meet

The Congress of County Medical Societies will hold its Annual Convention November 6-8 in Cincinnati, Ohio. Wesley W. Hall, M.D., president-elect of the American Medical Association, and Robert J. Myers, chief actuary of the Social Security Administration under five presidents, will be the keynote speakers.

Further information can be obtained from M. Robert Knapp, M.D., 1029 United Towers, Oklahoma City, Oklahoma 73112.

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NEWS ITEMS

Charles D. Leonard, M.D. has recently joined the faculty of the University of Kentucky Medical Center. A 1963 graduate of Washington University, Doctor Leonard completed his residency in 1968 at the University of Washington, Seattle.

M. Allen Dawson, M.D. is practicing in Lexington. Associated with Doctors Lee Shine and William T. Maxson, Doctor Dawson has a specialty in internal medicine and gastroenterology. He graduated from and completed his residency at the University of Kentucky.

Marlow R. Harston, M.D., a psychiatrist, is now director of the Community Mental Health Center in Paducah. Doctor Harston was formerly director of the Bute Mental Hygiene Clinic and the Mental Health Center, Utah City. He graduated from Northwestern University in 1946.

Edward N. Humston, M.D. has recently moved to Harrodsburg and is associated with G. T. Ballard, M.D. After graduating from the University of Louisville and serving his internship at St. Joseph Infirmary in Louisville, Doctor Humston engaged in general practice in Arkansas City, Kansas, from 1964 to 1970.

Russell R. Rice, M.D. has begun practice with Doctors Gillim, Potts and Ware. He graduated from George Washington University in 1964 and took his residency at the Chicago Lying-In Hospital from 1967 to 1970.

Frank G. Simon, M.D. is now practicing with Frank A. Simon, M.D. in Louisville. Doctor Simon graduated from Tufts Medical School in 1967 and completed his residency at the University Medical Center, Boston, in 1970. His specialty is allergy and clinical immunology.

Kenneth R. Rosenberg. M.D. has joined Medical Anesthesia Associates in Louisville. A University of Louisville graduate, Doctor Rosenberg took his residency at Louisville General Hospital in 1968 and served with the U.S. Navy for two years.

Parviz Partovi, M. D. is now practicing in association with Doctors G. L. Simpson and G. H. Rodman, Greenville. A 1961 graduate of the University of Tehran, Iran, Doctor Partovi completed his residency at University of Louisville hospitals in 1967. He served two years in the Iranian Imperial Air Force before returning to Kentucky.

FOUND, a man's ring in Convention Center, KMA Annual Meeting. Owner please call KMA Headquarters.

Kenneth F. VonRoenn, M. D., a psychiatrist, is now practicing in Louisville. A 1965 graduate of the University of Louisville Medical School, Doctor VonRoenn took his internship at St. Joseph Infirmary, Louisville and completed his residency in psychiatry at the New York Hospital.

Richard W. Dowdell, M. D. is now practicing with Doctors J. Wolford and R. Dame, Louisville. An internist, Doctor Dowdell graduated from the University of Louisville School of Medicine in 1963. Before returning to Louisville to practice, Doctor Dowdell served in the United States Air Force from 1967-69.

Harold Lee Reams, M.D., is associated with Walter D. Harris, M.D., Lexington. After graduating from Vanderbilt in 1962 and serving his internship at Vanderbilt Hospital, Doctor Reams completed his residency in otolaryngology at Barnes Hospital, St. Louis, Mo.

James G. Gay, M.D., is practicing at the Lexington Clinic. A cardiologist, Doctor Gay attended the University of Virginia Medical School, interned at the University of Virginia Hospital and took his residency at the University of Virginia Hospital and the University of Kentucky Medical Center.

Rodgers Q. Bailey, M.D., Louisville, is practicing in association with John M. Baird, M.D., and Charles W. Sisk, M.D. Doctor Bailey graduated from the University of Kentucky in 1969 and interned at the Memorial Medical Center, Savannah, Georgia.

W. Neil Padgett, Jr., M.D., has recently located in Owensboro. He graduated from the Medical College of South Carolina in 1963; he also interned and served his residency there. Doctor Padgett, whose specialty is obstetrics and gynecology, has recently completed 2 years with the U.S. Navy.

Joseph T. Fuqua, M.D., a specialist in internal medicine, graduated from Vanderbilt University in 1964. He interned at Vanderbilt, served 2 years with the U.S. Navy, completed his residency at Washington University and is now practicing in Hopkinsville.

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Point of View

(Continued from Page 676)

operation of such a computer is too expensive. Surprisingly, however, IBM has recently published brochures lauding the University of Kentucky Medical Center as having an ideal type of laboratory computerization.

The study makes no mention of the teaching and consultative function of the university laboratory. One is left with the feeling that such a role or request would be an imposition.

An evident lack of understanding of personnel policy and relationship between various personnel categories seems to exist on the part of the investigator. His suggestion that the B.S. medical technologist, the technical/scientific personnel (presumably including Doctors of Philosophy), and aides with perhaps a high school diploma should be lumped into one category so as to improve laboratory flexibility could have only one result—CHAOS ON THE CAMPUS

Edward J. Fadell, M.D.
Director of Laboratories
Methodist Evangelical Hospital
Louisville, Kentucky

Reference

Report 307C, Spindletop Research, April 1970.

Cholera In The New World

(Continued from Page 658)

shortly after admission. Rigor mortis appeared early. Autopsy was permitted and an El Tor vibrio was isolated on culture.

In 1941 George McCoy, M.D., served as professor of public health at the Louisiana State University Medical School. He had recently retired from the U.S. Public Health Service. In 1902 Doctor McCoy had been stationed in the Philippine Islands and had worked with Cholera during the severe epidemic of that year. He inspired an interest in the history of Cholera that has continued with me to this day. It was the same Doctor McCoy who with Chapin isolated Pasturella tularensis in 1912, while studying an epizootic among rodents in Tulare County, California.

Cholera exists today as it always has in southeastern Asia. The disease could be eradicated. Religious and cultural barriers stand in the way. Fortunately the great epidemics of the 19th Century that struck Europe and America are not likely to return.

Finally, may I say that I'm fully aware how much has been left unsaid. If I have leaped from one mountain top to another I ask your indulgence. I have presented only a bare outline of Cholera in the New World.

Bibliography

1. Cecil and Loeb, *Textbook of Medicine,* 9th Edition, W. B. Saunders Co., 1955.
2. Chambers, J. S., *The Conquest of Cholera,* MacMillan Co., New York, 1938.
3. Duffy, J., *Epidemics in Colonial America,* Louisiana State University Press, 1953.
4. Ernst, R., *Immigrant Life in New York City, 1824-1863,* New York, King's Crown, 1949.
5. Garrison, F. H., *History of Medicine,* 4th Edition, W. B. Saunders Co., 1960.
6. Hirsch, A., *A Handbook of Geographical and Historical Pathology,* Vol. I, Acute Infectious Disease, Translated from the 2nd German Edition by Charles Creighton, M.D., London, 1883.
7. Kramer, H. D., *Early Municipal and State Boards of Health,* Bulletin of the History of Medicine, XXI, May-June, 1947.
8. Longmate, N., *King Cholera,* The Biography of a Disease, H. Hamilton, Ltd., London, 1966.
9. Musser, J. H., *Internal Medicine,* 4th Edition, Lea and Febiger, 1947.
10. Powell, J. H., *Bring Out Your Dead,* U. of Pennsylvania Press, 1949.
11. Rosenberg, L. E., *The Cholera Years, The United States in 1832, 1849 and 1866,* The University of Chicago Press, 1962.
12. Rosenberg, L. E. *The Cholera Epidemic of 1832 in New York City,* Bulletin of the History of Medicine XXXIII, Jan.-Feb., 1959
13. Stitt, *Diagnosis, Prevention and Treatment of Tropical Diseases,* 7th Edition, Vol. I, 1944, The Blakiston Co.
14. Winslow, C., *The Conquest of Epidemic Disease,* Princeton University Press, 1943.

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References

1. Evans, Alfred S., Infectious Mononucleosis in University of Wisconsin Students. *American Journal of Hygiene.* 71: 342-362, 1960.
2. Schulz, Linda L., Pachibul, Franz, Diagnois of Infectious Mononucleosis by a Rapid Differential Slide Test. *Current Therapeutic Research.* 9: 582-585, 1967.
3. Levinson, M. L., and Frank, P. F. Differentiation of Group A from other Beta Hemolytic Streptococcus with Bacitracin. *Journal of Bacteriology.* 69: 284-287, 1955.
4. Moody, M. D., Siegel, A. C., Pittman, B., and Winter, C. C., Fluorescent Antibody Identification of Group A Streptococci from Throat Swabs. *American Journal of Public Health.* 53: 1083-1092, 1969.
5. Davidsobn, I. and Henry, J. B., *Todd-Sanford Clinical Diagnosis by Laboratory Methods,* 14th Edition 1969, p. 281, W. B. Saunders, Publisher.

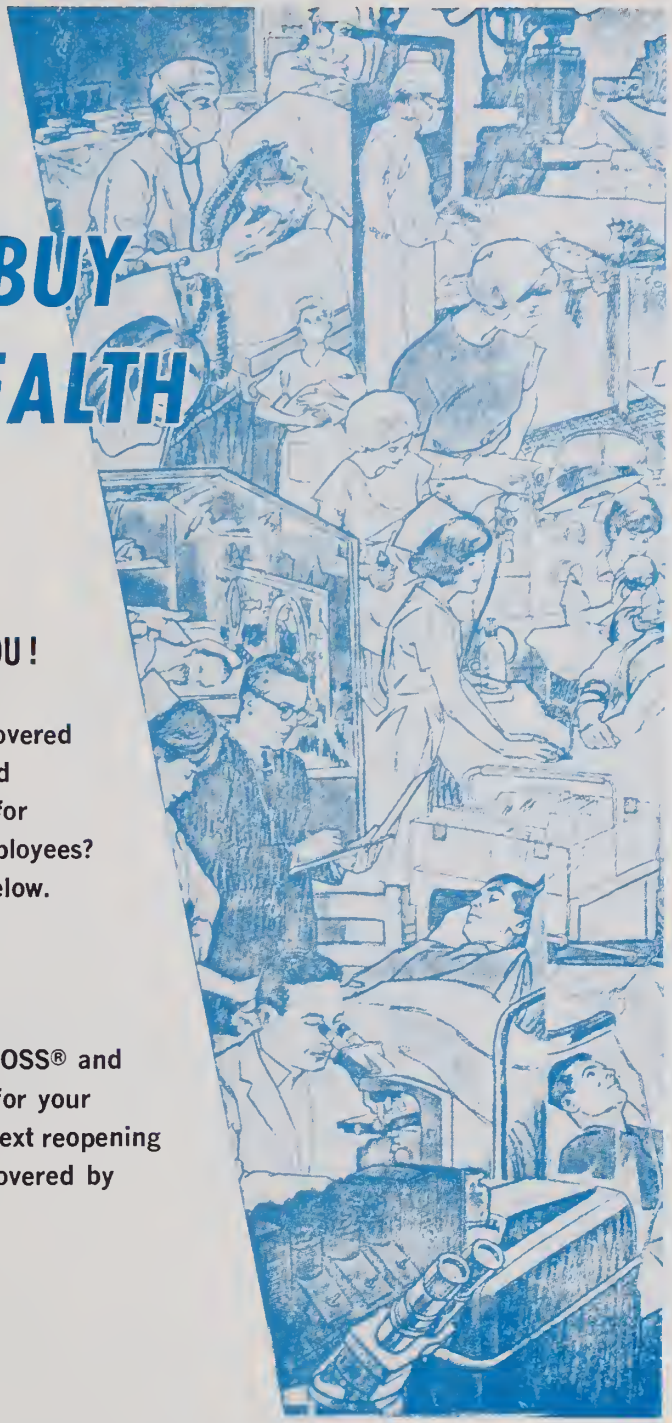
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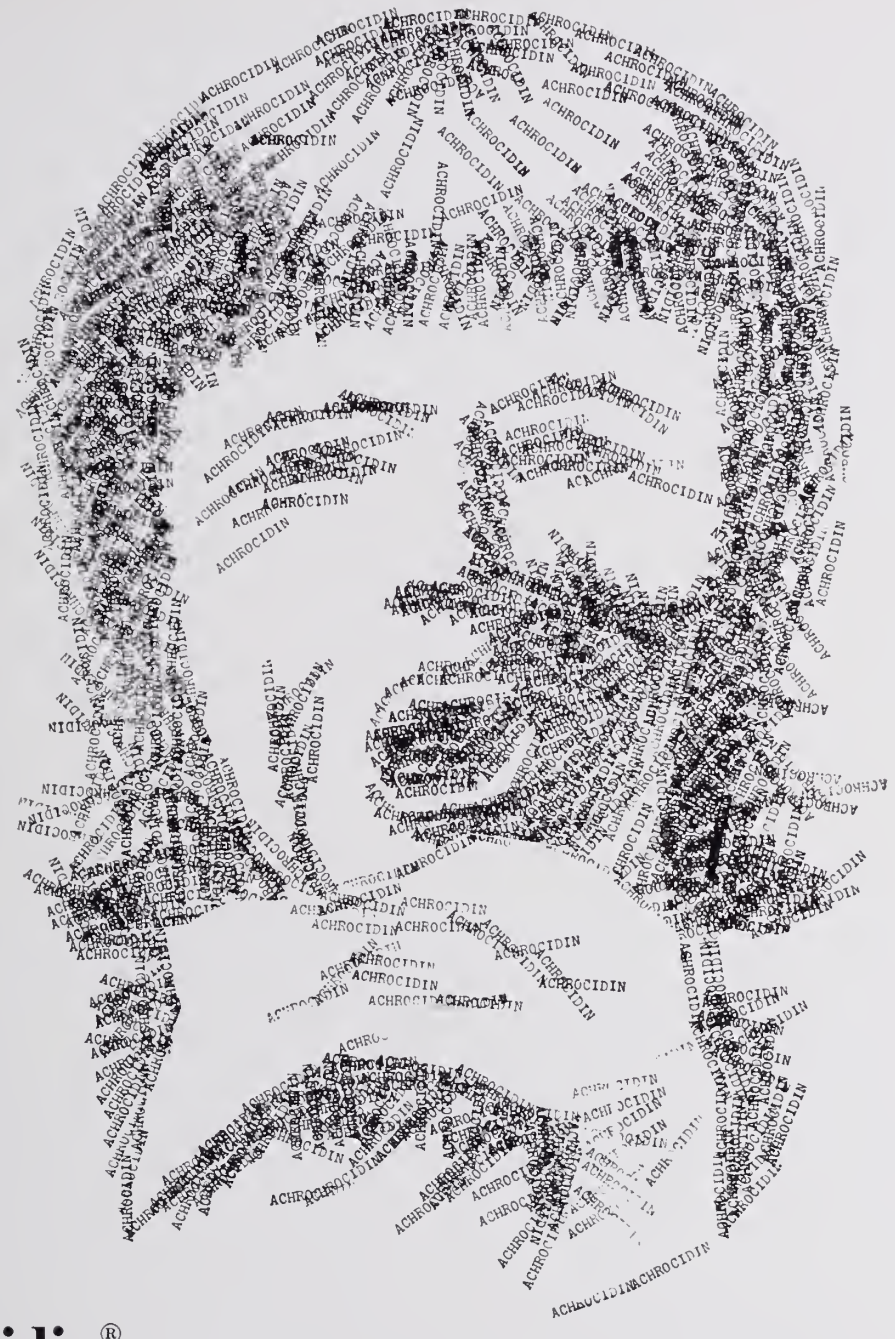
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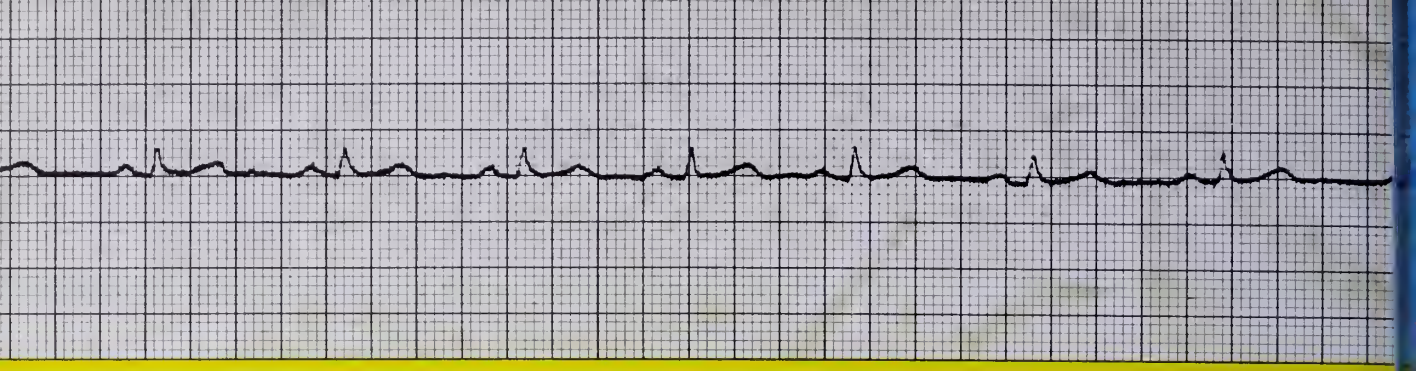
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(1) Siver, R. H.: CMD, **21**:109, September 1954. (2) Frykman, H. H.: Minn. Med., **38**:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., **51**:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., **15**:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., **58**:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., **18**:410-415, May 1970.

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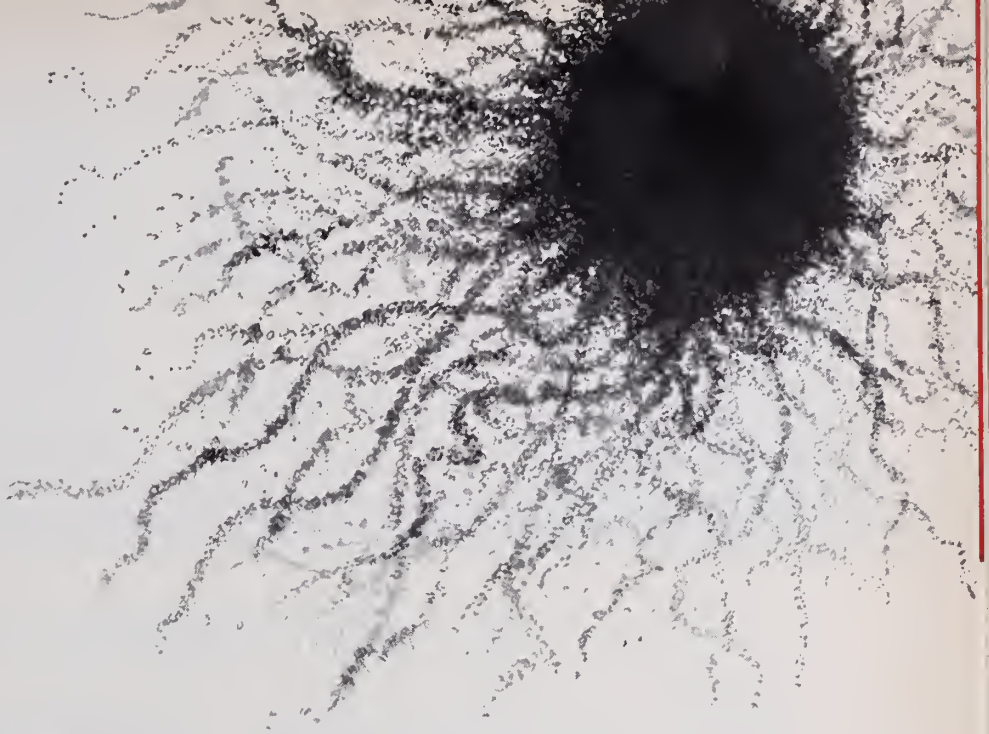
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MESSAGE FROM THE PRESIDENT



Some Observations On Health Insurance

IT WOULD be of little service if I were to use this page for the next year bemoaning "what might have been." What might have been is simply that the physician and his patient could have been left alone by all outside parties; and the physician would practice medicine as he saw fit. What will be within a short time is some form of National Health Insurance. Happily, the Nixon administration feels that "universal financing is not the same as universal access" to health care. This coincides with our thinking and is very reassuring.

We must gird ourselves for the changes that will accompany the inception of NHI and must assist in making health care as accessable as possible. Accessability in this case may be defined as easy physical and financial availability of top notch medical care to all classes of people.

To private, and especially my contemporary private, solo proctitioners the coming of NHI will be an unhappy event, for we justly feel we have made an outstanding contribution—but this is our country and its people are our friends and patients and we must be part of the evolution whatever it may be. Hopefully, we will be leaders in defining the ultimate structure of NHI.

More and more county, community, and private hospitals are unwilling to absorb the financial burden of the "charity" patient so, even though the doctor is quite willing to continue the time honored system of reducing or forgiving his fees for the poor, the doctor's share of the medical dollar is too small to have a significant impact on the total picture. The doctor will not be left out of the new medical "system," so it is apparent that the epoch of the "charity" patient is over.

It is a fact that many people can't afford the hospital and drug costs of medical care or even the insurance to provide it. Very few people are able to finance a catastrophic illness. But it is also a fact that people who can afford liability and collision insurance on their automobiles, for very little more, can also pay the premiums on very fine sickness insurance, and not have to worry about the financial effects of illness. This group constitutes the vast majority of the American people.

I tend to believe that some guidelines or regulations concerning quality of sickness insurance to determine "optimal adequate coverage" are in order, because there is no doubt that some policies are better than others and few people know what their insurance covers until too late.

I am not sure that competition in the health insurance business has reacted to the benefit of the consumer in every instance.

The physician has found, to his sorrow, that competition, without regulation, has left many of his colleagues without malpractice insurance (cite Hawaii's recent dilemma) and the medical profession is asking for drastic changes in the system.



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THE INSURANCE PAGE



Medical Records

We have said much about peer review in the past and we continue to hear that peer review is a vital part of medicine in the future. There can be no review of any kind without adequate medical records.

Almost all of the writer's generation, after completing an internship, noted that the low man on the totem pole did most of the writing; and in hospitals that were fortunate enough to have interns, the attending physician did very little writing. This observation seems to inspire them to resolve not to make any records when they enter private practice.

The busy doctor does not have time to write voluminous history and physical examination, and some doctors, no matter how busy, seem to resent the fact that they write any records at all and object very strongly to review of their records by anyone, peers or otherwise. With third party payment, review of records is inevitable. Since most of the population is now covered by some type of third party payment, doctors should assume that their records will be reviewed.

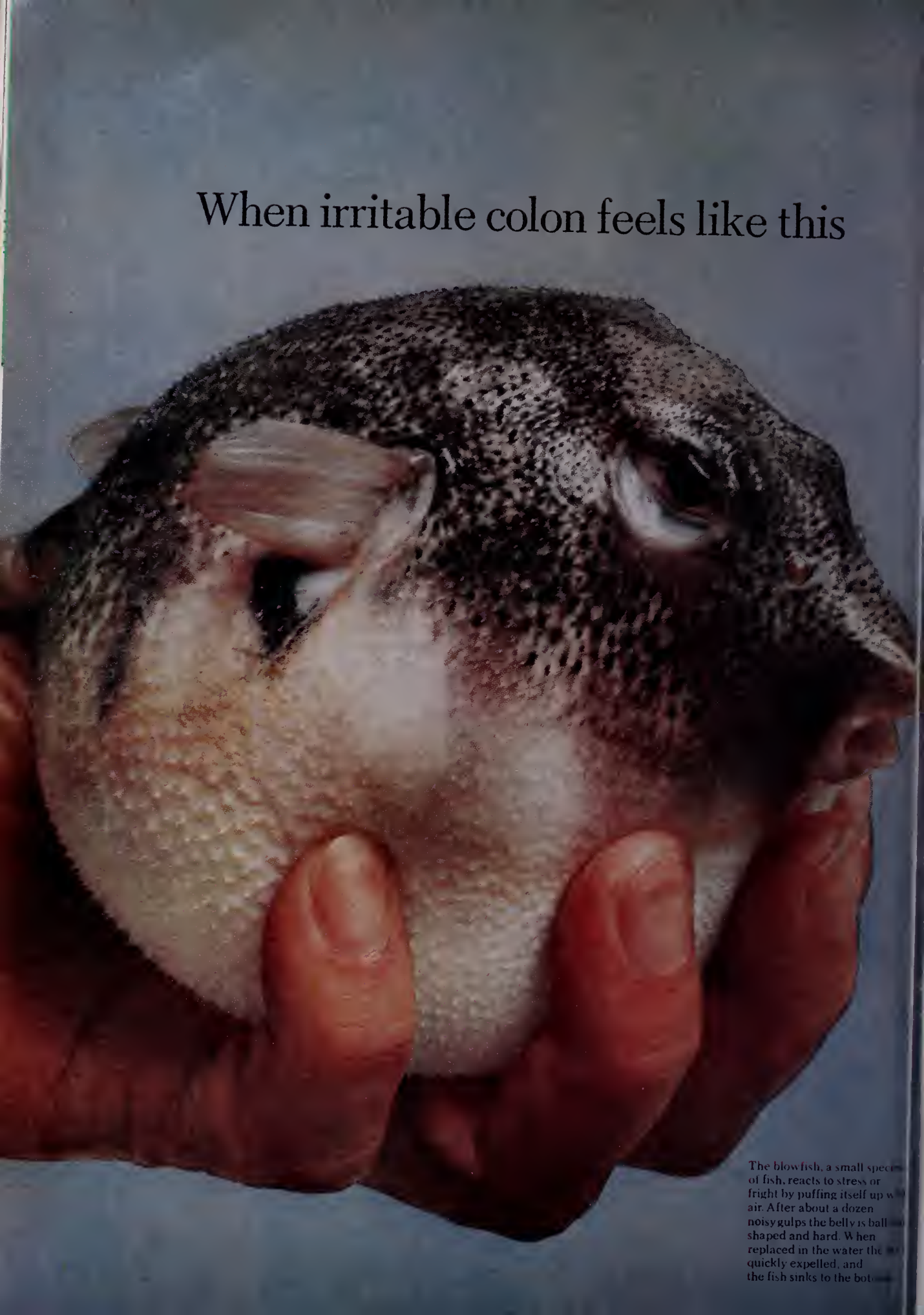
Physicians need further training in writing down the essential facts in each case. The key word is documentation. That is, the physician needs to learn to write down the pertinent facts which prove the diagnosis and shows what questions were asked and what examination was done. Not only positive findings must be recorded, but pertinent negative findings must be recorded to prove the exclusion of certain other conditions which must be considered in the differential. When doctors learn to keep accurate and adequate records, they need not fear interrogation in court or review by anyone.

Since the advent of Medicare and Medicaid, doctors have been subject to criticism in the press. We read about doctors who see more than one hundred patients daily, and it is apparent that the doctor has little time to make records. Such a doctor is in need of the new doctor's assistant we read about. It is apparent that one doctor seeing more than one hundred patients a day must have several assistants. The writer sees nothing wrong in a physician having several assistants, and training them to write histories and physicals and records of treatment as he dictates it. The physician may assign each patient to an assistant very much the way that physicians assign patients to medical students. Assistants are capable of obtaining much time consuming information and data and presenting it for the physician. They are capable of writing down on the chart what prescriptions were given and instructions given to the patient. In this manner the physician who sees more than one hundred patients daily has incurred much more expense than the physician who sees fewer patients. However, he must earn his fee by producing records which show what has been done.

However records are made, whether they be hand written, dictated, typewritten, or written by a medical assistant, all of us need to make adequate records. It is inexcusable in this day for a physician not to make records of each patient contact. One suspects that many who protest so loudly about not having adequate time to make records may be among those who do not have adequate time to make examinations.

LEWIS DICKINSON, M.D.

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fright by puffing itself up w
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noisy gulps the belly is ball
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replaced in the water the
quickly expelled, and
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Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

Dosage: Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.



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PUBLIC HEALTH PAGE

Greetings From The Commissioner

William P. McElwain, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

THE opportunity to serve as the Commissioner of Health is a distinct personal honor. Doctors J. N. McCormack, Arthur McCormack, P. E. Blackerby, Bruce Underwood and Russell E. Teague have all occupied the office with great distinction to themselves and the Commonwealth of Kentucky. It is our hope that such distinction will continue.

The challenges and frustrations of the position are surpassed only by the opportunity it affords.

Everyone talks and writes about the crisis in American medicine. The practice of Public Health is in a plastic state with traditional practice being outmoded and the new practice not clearly delineated. Environmental concern is at a level previously unknown in this country. Medical administration is unequalled in its complexity and importance.

In addition, the State Department of Health is the interface between the Federal government with its great variety of funding mechanisms and the communities with their many needs for service. It is the interface between the huge program of medical care for the indigent and the professional groups providing that service. The Department must integrate the concern of the average citizen, the conservationist and the industrialist in the maintenance of our environment.

The sum of these elements is a fascinating challenge that we intend to pursue with great vigor and every expectation of a reasonable measure of success.

The readers of this *Journal* are familiar with the great contribution the Kentucky Medical Association has made in the past to the development of the health of the citizens of this Commonwealth. The many expressions of support and offers of assistance that have come from the members and officers of the Association assures the continuation of that contribution and so makes what could be an impossible task one that will only be somewhat difficult.

I beg your interest and solicit your understanding and support as we begin to tackle the job before us. The health care system of our state and country is too important for it not to have the involvement and effort of every physician in the state.

Our office will always be open to you.

With your help there will be no question about Kentucky's ability to successfully meet the challenge before us.

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AVC
The treatment is singular

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

THIS twenty-three year old married white gravida 1, para O, had an expected delivery date of March 23, 1967. She was seen initially on August 11, 1966, weight 170 pounds; normal weight was 165. Her father was diabetic. Physical examination revealed no abnormalities, except for a slight narrowing of the transverse diameter of the mid pelvis. Blood type was A Rh positive, non-reactive VDRL, hematocrit 39%, WBC 9,500, Hb 13.1, urinalysis negative.

The prenatal course was uneventful except for slight fluid retention during the last month of pregnancy which was treated with diuretics. Her blood pressure remained within a normal range except for an elevation in the last week to 130/80.

Labor began spontaneously on April 1, 1967. She was admitted to the hospital having contractions every five minutes, of fair quality. Examination revealed the blood pressure to be 142/80; her physician felt the elevation of the systolic reading was due to apprehension. The cervix was one finger dilated, fetal vertex at minus one station, membranes intact. She was given the usual enema, prep and 75mg. of Atarax and Aquamephyton. Labor proceeded slowly and the contractions were described as of poor quality. She received oral clear liquids.

Approximately twelve hours following admission to the hospital at 12:10 a.m., the contractions were described as lasting 45 - 50 seconds, occurring every two to six minutes. She was five centimeters dilated, the presenting part minus one to zero station. She was sedated with Nisentil, Scopalamine, and Lorfan and received 1000 cc D5W intravenously. The membranes were still intact; fetal heart tones were normal, as well as blood pressure. Eighteen hours from time of admission vaginal examination revealed the cervix to be six - seven centimeters dilated, presenting part at station zero. The membranes were artificially ruptured and the quality of the contractions improved. The blood pressure and fetal heart remained normal. She was placed in the Sims' position in order to help rotate the head of the infant from occiput transverse to anterior. This was not successful.

Complete cervical dilatation occurred approximately twenty-eight hours following admission; however, the fetal vertex remained a persistent transverse. She received a general anesthetic of Nitrous Oxide, Oxygen and Cyclopropane; manual rotation of the fetal head was performed and an eight pound, two ounce girl was delivered. There was an extension of the episiotomy; however, the bleeding was described as minimal. The placenta was expelled intact and intramuscular oxytocin was given. The episiotomy was repaired in the usual manner. Blood pressure remained normal and after she awakened she was moved to the floor. At 11:00 a.m. her blood pressure was 100/70, pulse 88, respiration 18.

At approximately 11:30 a.m. she complained of having shortness of breath and acute substernal pain. Her blood pressure was 160/110. At 11:40 the patient was unconscious and an emergency call was issued. A cutdown was performed to establish an IV and an endotracheal tube was inserted. Artificial respiration, plus cardiac massage, as well as cardiac shock by a cardologist, was carried out. All means of resuscitation failed and she was pronounced dead at 12:15 p.m., approximately 35 minutes following the acute episode. There was no autopsy; the cause of death was listed as a massive pulmonary embolus, probably originating in the pelvis.

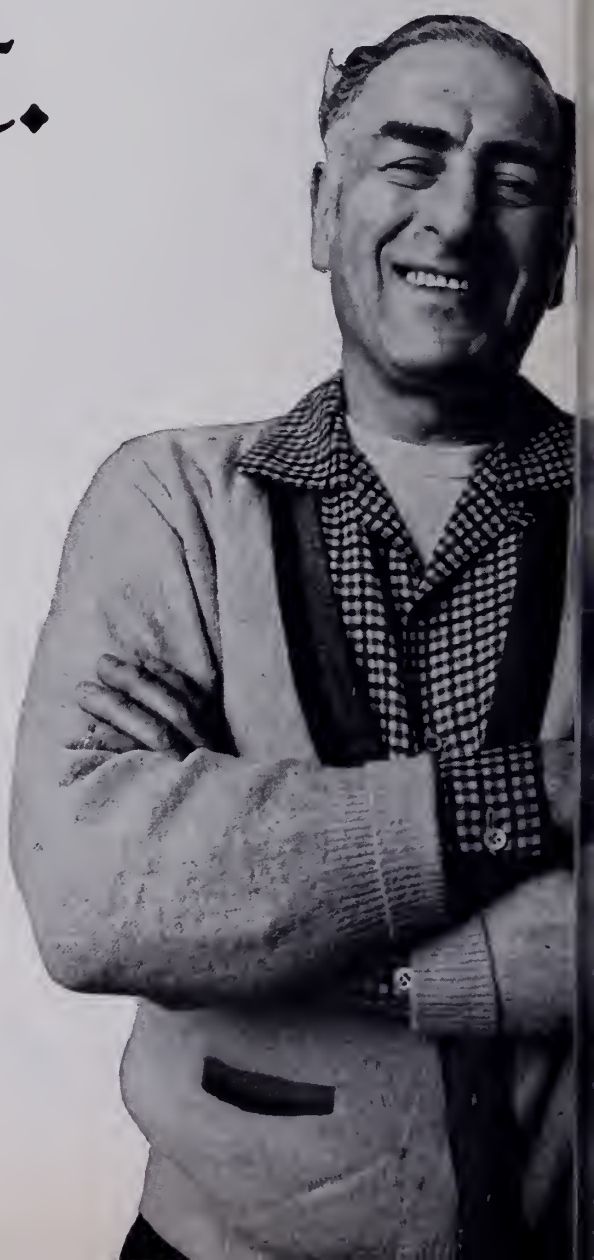
Comments

This case again emphasizes the importance of having an autopsy. While the clinical situation certainly seemed that this woman died of a massive pulmonary embolus, we cannot be certain of this. The Committee classified this death as obstetrical, probably non-preventable on the basis of the information supplied. It is also possible that the cause of death could have been a concealed post-partum hemorrhage, although this is unlikely in the short period of time that the acute episode occurred. Since there was a family history of diabetes, it is possible that coronary occlusion could have been the cause of her death. Coronary artery disease is frequently associated with Diabetes Mellitus. Another possibility was a dissecting aneurysm.

The Committee discussed the length of labor and felt that perhaps steps could have been taken to shorten her labor; but one could not definitely implicate the prolonged labor with the cause of her death, although numerous studies have indicated that there is an increased morbidity and even mortality when labor is prolonged. It would seem that the length of labor has gradually shortened over the last several years. Whether this is due to improved care during labor or the general health of the mother has not definitely been established.

Although the delivery is not described as being traumatic, it might have been, thereby causing trauma to the pelvic vessels, producing a blood clot that could subsequently become a fatal pulmonary embolism. However, without an autopsy we are ignorant of the exact cause of this woman's death.

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Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

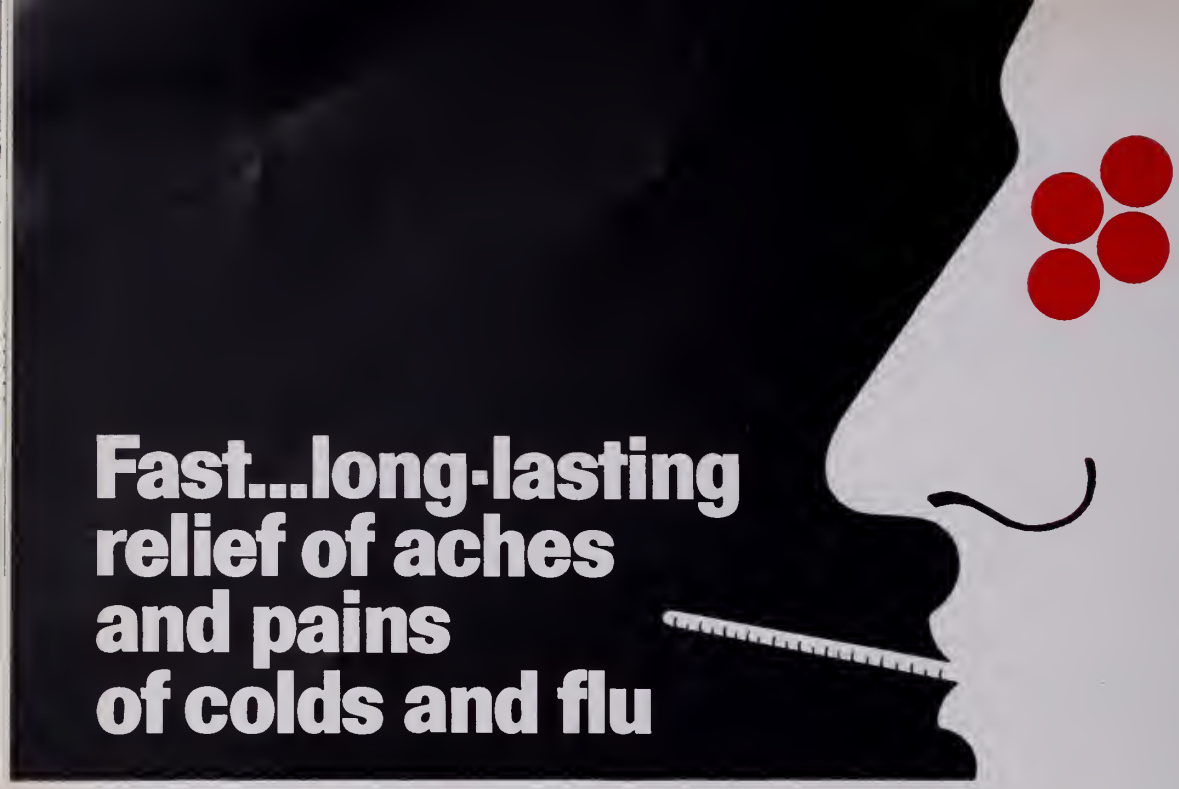
Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

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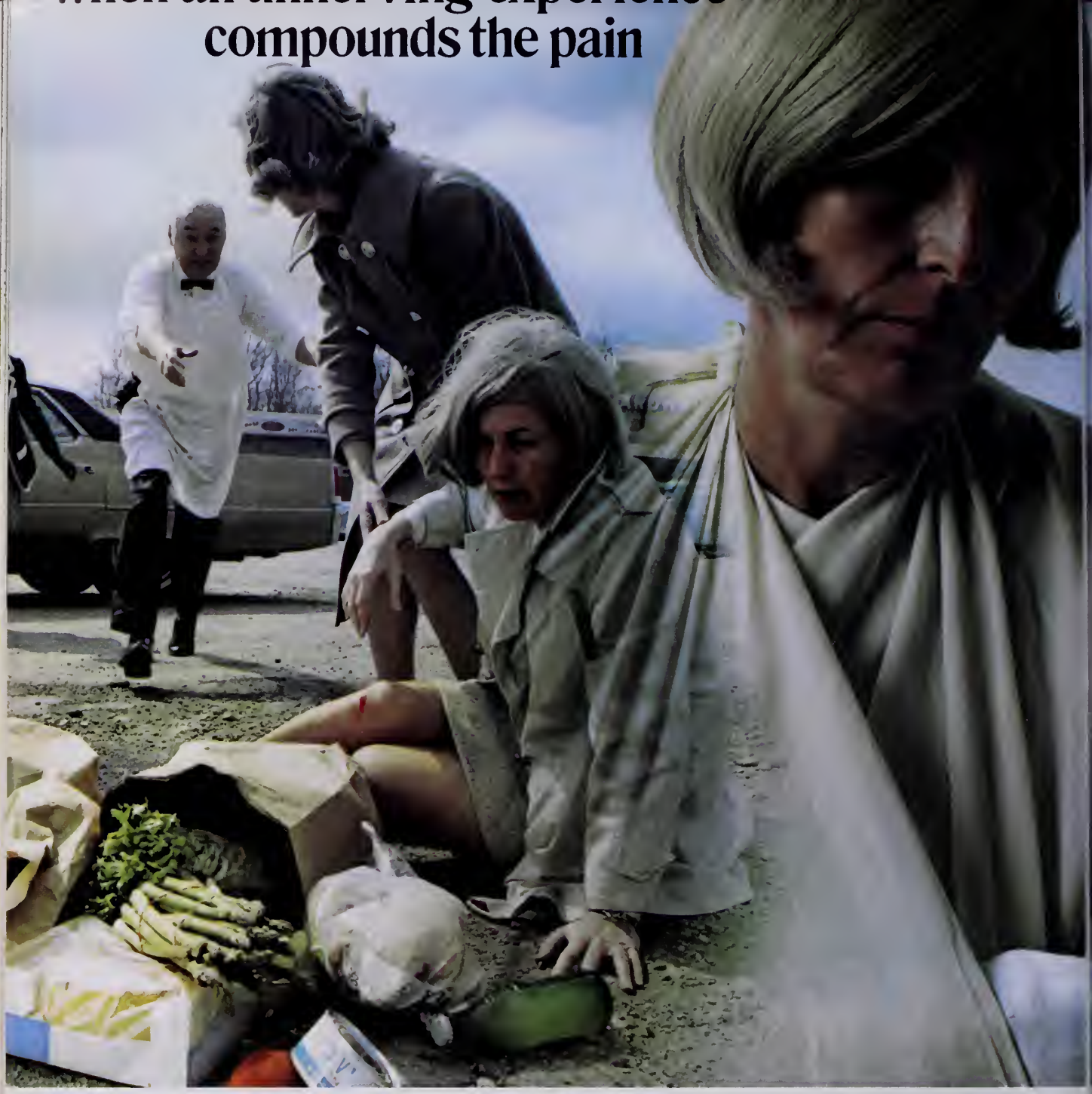
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the compound analgesic that calms instead of caffeinates

In addition to pain, this patient has experienced anxiety, fear, embarrassment, and frustration. No doubt these psychic factors actually increased her perception of pain. Surely the last thing she needs is an analgesic containing caffeine. The logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?

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Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming). **Indications:** Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.
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EDITORIALS

Medicaid Nightmare

PREDICTABLY, Title XIX—Medicaid—came in for considerable discussion during the recent session of the House of Delegates at the Annual Meeting of the Association.

Much heat was generated during these discussions, as physicians from over the state expressed their frustrations, their disappointments and their disgust over the manner in which the program has been administered in Kentucky, and the criticism and poor publicity accorded physicians as a result of defects in the program over which we have no control.

Proposals ranged from complete withdrawal of KMA's approval of Title XIX, to a withdrawal of our Technical Advisory Committee, to a statement of the deficiencies and inequities in the administration of the program to be widely distributed to our legislators in Washington, the Governor and other state officials and to the communications media.

Wisely, it would seem, the House adopted the latter proposal, and the directive it contained has been implemented.

In listening to the discussion on that Wednesday night, two thoughts came to mind. First, there still exists a "communications gap" between KMA and its members—in spite of every effort on the part of the officers and the Board of Trustees to keep the members informed of their actions in regard to Medicaid (as well as all of the other activities and programs of the Association) through *The Journal,* the *Communicator,* special bulletins and letters and district meetings. One can only conclude that many members, including, unfortunately, a few delegates, do not read the information provided to them, nor do they attend meetings.

Second, and resulting from the above, there is still considerable confusion in regard to the administration of the Medical Assistance Program in Kentucky. By law the Department of Economic Security is the sole state agency responsible for this program. That department contracted with the Department of Health to administer the medical aspects of the program, and this is done by the office of KMAP within the Health Department.

Economic Security determines the eligibility of beneficiaries to participate in the program.

KNAP receives the Physician's claims, processes them, determines the payment due, and certifies the payment to Economic Security, which then writes the check.

This complicated arrangement has confused not only the physicians but also the people in Frankfort. And their confusion has been compounded by an appalling lack of cooperation between the two departments.

Although we may all agree that the standards for determination of eligibility for benefits apparently leaves much to be desired, and we are certainly justified in questioning the information given the beneficiaries by the Department of Economic Security in regard to the scope of benefits, that portion of the discussion before the House was not relevant since these criticisms did not appear in the body of any of the resolutions.

Most KMA officials who have been involved in the Title XIX discussions during the past year will agree that we have received more cooperation and understanding from Commission Merritt Deitz than from most any official of the state government since the Medical Assistance Program was instituted in the early Kerr-Mills days. To hear Mr. Deitz vilified by name for only two of the many, many faults

of the program would seem to violate one's sense of fair play.

We can be much encouraged by the words of the new Commissioner of Health, Doctor William McElwain, and have been impressed with the actions he has taken since his appointment. Let us hope that a new spirit of cooperation between the Departments of Health and Economic Security may develop and that KMA may have the opportunity to work with these two capable young administrators in an effort to correct the problems and inequities in that nightmare called Medicaid.

HENRY B. ASMAN, M.D.

A Day in the Life of ——

Recently Dr. Hypo Thetical attended a meeting in Lexington of one of the subcommittees of the State Comprehensive Health Planning Council—the Manpower Advisory Committee. This was just one of a number of similar committee meetings that he'd attended—probably the 4th or 5th meeting of this particular committee, but the pattern that emerged was similar to that occuring in many others. Driving the 73 miles home, he was buffeted by some pretty disturbing thoughts.

To the best of his knowledge, he was the only practicing physician on this committee. The luncheon meeting was set for 12 noon at the Carnahan House, a University of Kentucky facility outside Lexington. He got up at 6:15 a.m., had a minor surgical case at 7:30 a.m., made hospital rounds and was in the office by 10:00 a.m. He saw his office patients and was able to leave by noon or a little after. He calculated that he would arrive after the luncheon part of the meeting so he picked up a grilled cheese sandwich and ate it while driving to Lexington. The drive was fortunately uneventful, and his car did not suffer mechanical failure as it had on one of the previous trips to this committee in Frankfort. Nevertheless, it took an hour and a half to get there since he was not familiar with the location of the building.

Upon entering the meeting late, he sat down and became aware that it was a joint meeting of the Health Manpower Advisory Committee, and the representatives of the Comprehensive Health Planning Bodies of the 15 regions throughout Kentucky. These men, all good men, honest and well-motivated, were investigating the present status, interpreting the needs, and helping to plan the future development of the entire field of Health Manpower in this state! A major effort destined to affect us all!

With similar meetings, over the years, he had seen "consumers" with various levels of information and motivation, become increasingly involved, and gradually take over the concepts of planning for health and treatment of disease. The entry of the consumers into the field was of course a welcome one, but he felt they certainly needed advice from medical practicioners which, for a variety of reasons, they all too often failed to get. He had seen the attitude of some of these consumers (many of them bank presidents, industry leaders, etc.) change from "where are all the doctors, and why don't they come and help us," to an implied "we'll do it without the doctors; they are just a small voice on our big team."

Pertinent items: since Dr. Thetical made his living from the private practice of medicine exclusively, he was almost certainly the only one in the room whose time during that meeting was not being covered by his ordinary salary. He was also the only one in the room who stood to lose future income (referrals) by his presence there at that moment. Transportation, furnished to all the other health planners by their expense accounts, was not considered in his case. Practicing physicians have difficulty along this line!

What is the point in detailing this one physician's experience? With the economic and practical cards stacked so heavily against the participation of the practicing physician in such meetings, is it any wonder that conscientious physicians rarely are enthusiastic about neglecting practices, and family economic responsibilities, to take on such committee

chores? Is it any wonder, also, that government and educational groups tend to migrate toward committee patterns involving salaried physicians, if indeed they decide to involve physicians at all?

Because our near-absence does not obliterate the planning process, but simply leaves it to others, we as physicians are placed ultimately in the light to which we have unfortunately become quite familiar—that is to say, we are placed in the position of having a plan thrust upon us, and then protesting vehemently (and often quite rightly) that the plan is impractical, expensive, and will not achieve its desired results. People are tired of hearing negative thoughts from physicians, but this is, at least in part, how such positions and situations are developed.

This story could be repeated by scores of physicians throughout this commonwealth. It's not being told to indicate that those physicians who go to committee meetings are doing either the right thing or the wrong thing—it's just that we should become aware that the economic necessities of private practice produce certain side effects, of which this is certainly one.

Having driven three hours to attend one hour of a committee meeting, at which his education was moderate, and his contributions minimal, Dr. Thetical's enthusiasm for continuing on with monthly or bimonthly meetings of this sort seems to be waning. Should he leave Planning to the Planners?

WALTER I. HUME, JR., M.D.

Mark your calendar today . . . . . .

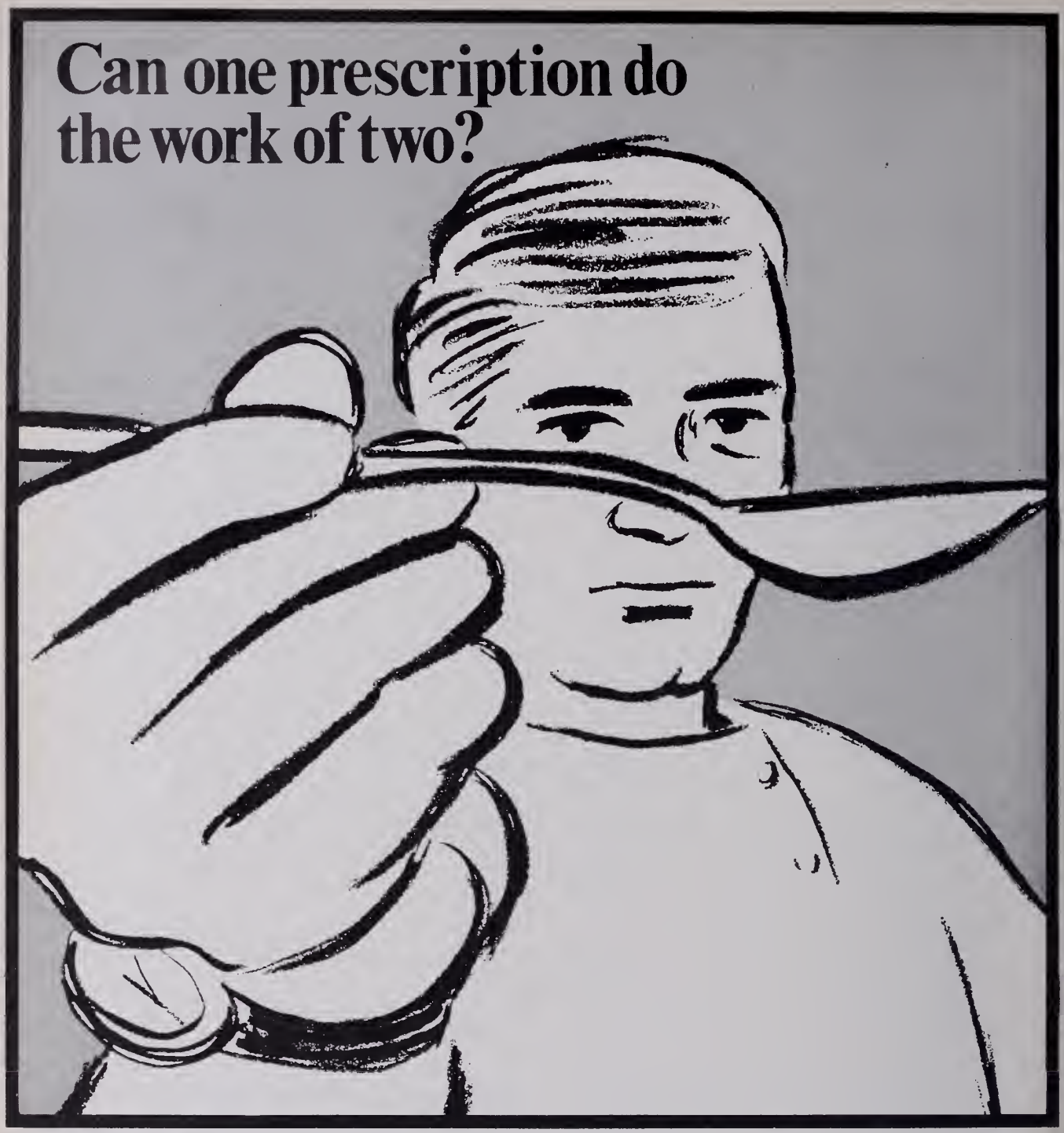
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18-19 Postgraduate course, "Practical Ophthalmology for the Primary Physician," University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

NOVEMBER

11-12 Postgraduate course, "Diagnostic Procedures in Gastroenterology," Cleveland Clinic Educational Foundation, Cleveland, Ohio

11-13 Postgraduate course, "Genetics for the Internist," American College of Physicians, New York

16-19 Annual Meeting, Southern Medical Association, Dallas, Texas

29-Dec. 2 Clinical Convention, American Medical Association, Boston, Massachusetts

DECEMBER

1-5 Postgraduate course, "Mico Dissection of the Temporal Bone," University of Cincinnati Medical Center, Cincinnati, Ohio

5-6 Annual Meeting, American Academy of Dermatology, Chicago, Illinois

7-10 Postgraduate course, "Pulmonary Function in Health and Disease," New Orleans, Louisiana

9-10 Postgraduate course, "Current Concepts in Opthalmology," Cleveland Clinic Educational Foundation, Cleveland, Ohio

JANUARY

7-9 National Conference on Cancer of the Colon and Rectum, Hotel del Coronado, San Diego, Calif.

9-20 Postgraduate course, Laryngology and Bronchoesphagology, University of Illinois, Chicago, Illinois

13-14 Postgraduate course, "Fifty Years of Surgical Progress," Cleveland Clinic Educational Foundation, Cleveland, Ohio

13-15 Postgraduate course, "Coronary Atherosclerotic Heart Disease: Prevention, Treatment and Rehabilitation," American College of Physicians, Atlanta, Georgia

18-22 Postgraduate course, "Recent Advances in Internal Medicine," American College of Physicians, Augusta, Georgia

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can to avoided and a wider audience can be informed of these upcoming meetings.

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VOLUME 68 NOVEMBER 1970 No. 11

The Cardiac Effects of Local Anesthetics

ROBERT B. BOETTNER, M.D.*

Lexington, Kentucky

The effects of local anesthetics on many factors, cardiac and extra-cardiac, which influence the performance of the heart are examined with the hope that this information may lead to their safe and rational use.

Since the discovery by Freud and Koller [1] in 1884 that cocaine could anesthetize the eye, local anesthetics have been used to produce regional anesthesia by topical application, infiltration, intravenous infusion, and by blocking conduction in major nerves. Mautz's[2] demonstration in 1936 that procaine, metycaine and cocaine could reduce cardiac irritability, when topically applied to the heart, expanded the use of local anesthetics to the treatment of cardiac arrhythmias.

High blood levels of local anesthetics secondary to intravascular injection (inadvertent or deliberate), rapid absorption from mucous membranes or highly vascular areas may lead to cardiovascular collapse. Hence a knowledge of the ways in which local anesthetics affect the cardiovascular system may aid the physician in their safe and rational use.

Although the physician is primarily concerned with the net effect of the various agents on the cardiovascular system as a whole, it is more convenient, and probably less confusing, to first examine the effects on each of the various parameters that determine cardiac performance. An attempt can then be made to integrate the responses of these various components to determine the net effect on the intact patient.

Local anesthetics have both chronotropic and inotropic properties. Chronotropism refers to influence on rate and rhythm and inotropism refers to the performance of the heart as a muscle or pump. The cardiac output, of course, depends on both, and is a product of the heart rate and the stroke volume, or the amount of blood pumped per beat. Before we examine the chronotropic and inotropic effects of local anesthetics in detail, two points need emphasis. First, these agents directly affect the heart and blood vessels per se and indirectly affect the cardiovascular system through their effects on the autonomic nervous system. These direct and indirect effects may be in the same or in opposite directions. Secondly, the response of tissue damaged by hypoxia, stretch or disease may be different qualitatively, as well as quantitatively, from the response of normal tissue.

Chronotropic Effects

Arrhythmias arise from disorders of (1) impulse formation and/or (2) impulse conduction. A knowledge of the electrophysiology of the heart is a prerequisite for understanding the mechanisms of arrhythmia production. A brief review of the electrical events leading to impulse formation and conduction and how these are altered by local anesthetics follows.

Impulse Formation

Hoffman and Cranefield[3] first described and recorded the sequence of electrical events which

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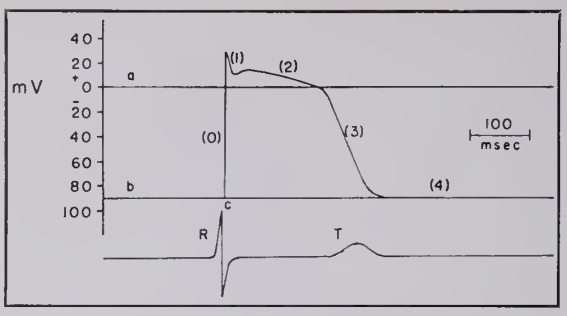


FIG. 1* The transmembrane actian patential of a typical non-automatic cell recarded from an intracellular micro-electrade is shawn an the top tracing. The resting potential (phase 4) af a quiescent fiber is about—90 mV. When the cell is stimulated it undergaes rapid depolarization (phase 0) with a transient reversal of palarity and then a mare gradual repalarizatian, (phases 1,2,3). A unipalar electragram recarded from the surface of the fiber is shawn an the battam tracing. Phase 0 carresponds ta the intrinsic deflectian of R, phase 2 to the ST segment and phase 3 ta the T wave.

*Madified after Hoffman, B. F., and Singer, D. H., Prog. in Cardiov. Dis. 7, 227, (Nov) 1964.

occur during depolarization and repolarization of a cardiac cell membrane. These events, referred to as the transmembrane action potential, are shown in Figure 1.

Specialized cells, "automatic cells," located in the SA node, atrium and His Purkinje system have the capability of undergoing spontaneous depolarization. If during phase 4 depolarization the membrane potential reaches a critical level (the threshold potential), an action potential is generated and the cell fires (Fig. 2A). Ordinary or "non-automatic cells" do not undergo spontaneous depolarization. Both specialized and ordinary cells may be depolarized by electrical currents which reach them as a result of action potentials generated by depolarization of adjacent cells.

The automatic cell, or group of cells, with the most rapid rate of firing becomes the pacemaker, provided the action potential generated is propagated.

The several factors which determine the rate of firing of an automatic cell are illustrated in Figure 2B. These include (1) the rate of spontaneous depolarization (slope of phase 4) (2) the threshold potential or the potential which must be reached in order to generate an action potential and (3) the maximum negative potential developed during diastole.

The rate of firing of automatic cells is normally most rapid in the SA node, less rapid in the atrium, less yet in the His bundle and least in the Purkinje cells. Arrythmias may result from physiological or pharmacological factors which depress the primary pacemaker or enhance the automaticity of latent pacemakers. For a summary of the effects of pH, pCO_2, stretch, hypoxia, ischemia, catecholamines, acetylcholine and various ions on transmembrane action potentials see the excellent review by Singer and Ten Eick.[4]

Local anesthetics, and other anti-arrhythmic agents, in therapeutic dosages affect automaticity primarily by decreasing the slope of phase 4—thus slowing the rate of firing of automatic cells. Toxic doses, however, may increase the slope of phase 4 and decrease the maximum negative potential developed during diastole, thus producing tachycardias. In the patient, influences of the autonomic nervous system may override the direct effects of local anesthetics. Stimulation

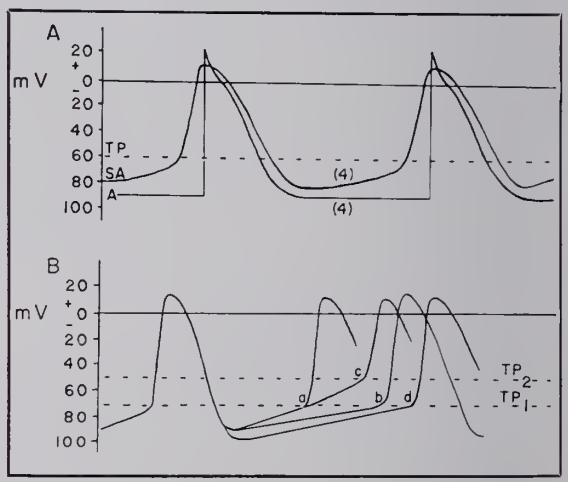


FIG. 2A Differences between transmembrane action potentials from the sina-atrial nade (SA) and a non-autamatic atrial fiber (A). Note spantaneaus phase 4 depolarization in the autamatic (SA) cell. The amplitude af the action potential and rate of rise (dv/dt) of phase 0 (rapid depolarizatian) are less in the autamatic than in the non-autamatic cell. TP = the threshold potential or the potential which must be reached in arder to generate an action potential.

FIG. 2B* Factors which influence the rate of firing of an autamatic cell. The rate may be decreased by: (1) making the threshald potential less negative (TP_2 vs. TP_1 curves c vs. a), (2) decreasing the slope of phase 4 (b vs. c), (3) making the maximum diastolic potential more negative (d vs. b). The rate may be increased by: (1) increasing the slope of phase 4, (2) increasing the negativity of the threshold potential ar, (3) decreasing the negativity of the maximum diastolic potentia).

*Fram Hoffman, B. G., and Singer, D. H.: Prag. in Cardiav. Dis., 7, 229, (Nov) 1964.

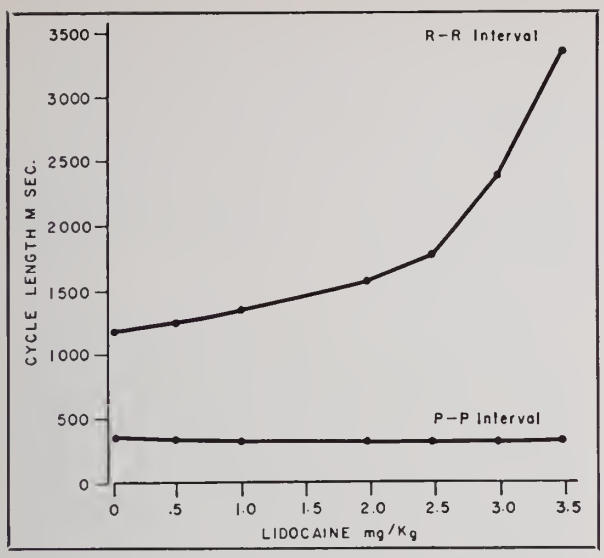


FIG. 3* Effect of lidocaine on atrial and ventricular pacemakers. The atrial pacemaker is not affected (P-P interval unchanged), the ventricular pacemaker is markedly slowed (R-R interval increased) with increasing doses of lidocaine.

***From Lieberman, N.A. and others: Amer. J. Cardiol, 22, 379, (Sept) 1968.**

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of the sympathetic nervous system tends to increase the slope of phase 4 depolarization—especially in ventricular cells—thus leading to ventricular arrhythmias. Parasympathetic stimulation decreases the slope of phase 4—thus slowing the sinus rate.

Since the vagal innervation is essentially limited to supraventricular cells parasympathetic stimulation may suppress these centers allowing ventricular pacemakers to take over. Winnie has proposed that sympathetic and/or parasympathetic stimulation operate via the above mechanisms to produce many of the arrhythmias which occur in patients under general anesthesia.

Marked differences in the response of the various cells to local anesthetics is illustrated by the findings of Lieberman[5] that atrial cells are little affected by lidocaine while increasing concentrations of lidocaine markedly slow the rate of firing of ventricular pacemakers (Fig. 3).

It is necessary to again stress that diseased cells may be partially depolarized and respond differently than normal cells to various stimuli and agents.

Disturbances Of Conduction

The ability of cardiac cells, both automatic and non-automatic, to respond to stimulation, the current necessary to elicit the response and the nature of the response all depend on the level of the membrane potential at the moment of stimulation. The more negative the membrane potential at the moment of stimulation, the greater the amplitude of the action potential developed and the steeper the slope of phase 0 or rate of rise (dv/dt) of that action potential.

Figure 4A depicts the response of excitable cells when stimulated at various times in the cardiac cycle. Note that stimulation at times when the membrane potential is less negative than the threshold leads only to local non-propagated responses. Figure 4B shows the current necessary to elicit a response at various times in the cardiac cycle. Note that except during the supernormal period the current necessary to elicit a response is least when the membrane potential is most negative.

Local anesthetics decrease the response to stimulation at a given membrane potential

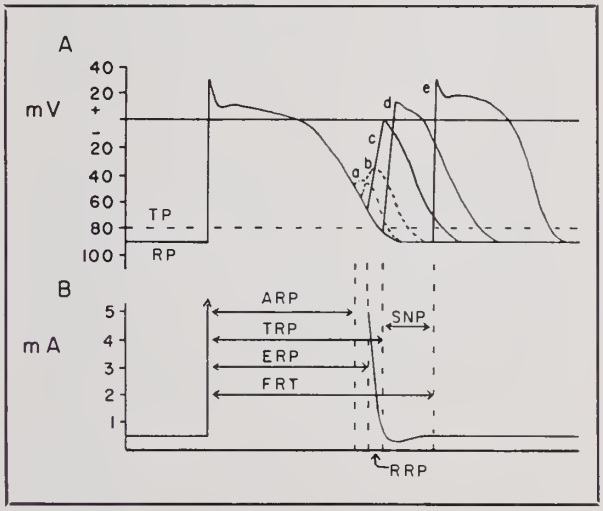


FIG. 4A Transmembrane action potential and the responses elicited by stimuli at various times during repolarization. The earliest responses, (a) and (b), are only local non-propagated responses, (c) is just able to depolarize the cell, and (e) is the first normal propagated response. Note the more rapid rate of rise dv/dt of phase 0 and the greater amplitude of the action potential of (e) as compared to the other responses.

FIG. 4B* The current, in milliamperes, necessary to produce a response at various times during repolarization. (ARP) = absolute refractory period—no amount of current is able to elicit a response, (ERP) effective refractory period, (TRP) total refractory period, (SNP) supranormal period, (FRT) full recovery time.

***Modified after Hoffman, B. F., and Singer, D. H.: Prog. in Cardiov. Dis., 7, 231, (Nov) 1964.**

thus impairing conduction. They also tend to slow repolarization, thus increasing the time during each cycle during which the cell is refractory to stimulation.

Both these factors, increased refractory period and decreased response at a given membrane potential, reduce the likelihood that premature impulses will result in propagated responses.

As was noted above in the discussion of automaticity there are marked differences in the sensitivity of various pacemaker cells to local anesthetics. Likewise the effect of local anesthetics on conduction varies in different parts of the heart. Lieberman[5] found that lidocaine markedly slowed conduction either at the junction of the atrium and A-V node or in the A-V node itself, but had little effect on other parts of the conduction system.

Both procaine amide and lidocaine may be effective against arrhythmias resulting from uni-directional block with re-entry. However, they act in diametrically opposite ways—lidocaine improves conduction by eliminating the uni-directional block while procaine further depresses conduction by converting the block to a bi-directional block. In either event, re-entry is prevented and the arrhythmia disappears.

The anti-arrhythmic properties of various drugs including local anesthetics may be assessed in various ways. Using a modification of a technique developed by Galindo and Sprouse,[6] we studied the ability of lidocaine, mepivacaine and bupivacaine to prevent premature ventricular contractions when currents of various strengths were applied to the heart via epicardial electrodes. All three drugs increased the amount of current necessary to elicit these premature ventricular contractions —i.e. all drugs were anti-arrhythmic.[7]

The ability of these drugs to protect the heart from arrhythmias, secondary to experimentally produced myocardial infarction and digitalis induced arrhythmias, is currently under investigation in the anesthesia research laboratories at the University of Kentucky Medical Center.

Inotropic Effects

The ability of the heart muscle to perform work (pump blood) is determined by three factors: (1) the pre-load or the amount of blood presented to the heart—this is reflected in the pressure in, or volume of, the ventricles at the end of diastole, (2) the contractility or inherent ability of the muscle to contract and (3) the after-load or resistance to the flow of blood from the heart. Drugs, including local anesthetics, influence these different parameters in varying degrees.

Quinidine and the amide of procaine were the most frequently used systemic agents for the treatment of ventricular arrhythmias until Harrison et al[8] indicated that lidocaine had fewer adverse effects on the cardiovascular system. They compared equipotent doses, as determined by elevation of the threshold to electrical stimulation, of procaine amide (2 and 4 mg/kg) with lidocaine (1 and 2 mg/kg) in patients undergoing open heart surgery. Procaine amide markedly decreased systolic arterial pressure and myocardial contractile force—the latter measured by a strain gauge sewn on the right ventricle. Lidocaine produced minimal changes in pressure (a slight increase with 1 mg/kg and a slight decrease with 2 mg/kg) and had no significant effect on myocardial contractile force.

Lieberman in 1968,[5] using an isovolumetric technique, was able to study the effects of lidocaine on myocardial contractility per se by eliminating variations in cardiac filling (pre-load) and resistance to ejection of blood (after-load). Lidocaine in doses of 0.5 to 2.0 mg/kg had little effect on contractility at various ventricular volumes, but higher doses significantly decreased both the maximum tension developed and the rate of rise (dp/dt) of that tension or pressure.

Jorfeldt[9] studied the effect on cardiac performance of several local anesthetics in man. Using doses equivalent to what might be used for major conduction anesthesia (e.g. femoral-sciatic nerve block, epidural anesthesia or axillary block of the brachial plexus), he found that 5 mg/kg of lidocaine, 5 mg/kg of mepivacaine and 1.25 mg/kg of bupivacaine had little effect on, or slightly increased, cardiac output, stroke volume and arterial pressure and had no effect on the central venous pressure. In right heart catheterization studies he found that mepivacaine slightly increased right ventricular and pulmonary

artery pressures without elevating right ventricular end-diastolic pressure, indicating that the positive inotropic effect was not due to stretching of the myocardial fibers (Frank-Starling mechanism).

Kao[10] found that 1 mg/kg of lidocaine significantly increased cardiac output, stroke volume, heart rate, arterial pressure and decreased peripheral resistance. Using various doses of mepivacaine, he found that doses up to 4 mg/kg increased cardiac output while higher doses decreased output. By using vagotomized, midbrain section, and cross-circulation preparations he demonstrated that these effects were central in origin—probably resulting from influence on the automatic nervous system.

Bonica[11] found that epidural anesthesia to a level of T3-4 increased cardiac output, heart rate and stroke volume, while spinal anesthesia to the same level had little effect on these parameters. He attributed the difference in effects to the higher blood levels of local anesthetic with epidural anesthesia resulting in central stimulation of the sympathetic nervous system.

Conclusions

It is no longer sufficient to summarize the cardiac effects of local anesthetics by saying that "they are cardiovascular depressants." The effects on the various parameters which determine cardiac performance are diverse.

Lidocaine is used clinically to suppress ventricular arrhythmias. It suppresses the automaticity of ectopic ventricular foci but apparently has little effect on higher pacemaker centers. Local anesthetics influence impulse conduction in the heart by slowing conduction through the A-V node. They help prevent propagation of ectopic impulses. In electrophysiological terms they: 1) decrease the slope of phase 4 depolarization 2) slow repolarization and 3) decrease the response of a cell to stimulation.

Dosages of local anesthetics commonly used to produce surgical anesthesia have little effect on myocardial contractility and may actually improve cardiac performance by stimulation of the sympathetic nervous system. Higher dosages however do have profound depressant effects and may lead to cardiovascular collapse.

Qualitative as well as quantitative differences exist between the effects of large and small doses of drugs and between the response of diseased and normal cells.

References

1. Freud, S., and Koller, C.: From Goodman and Gilman: *The Pharmacological Basis of Therapeutics,* 2nd ed., 355, The Macmillan Company, New York 1955.
2. Mautz, F. R., Reduction of cardiac irritability by the epicardial and systemic administration of drugs as a protection in cardiac surgery, *J. Thoracic Surg. 5,* 612, (Aug) 1936.
3. Hoffman, B. F., and Cranefield P. F., The Physiological basis of arrhythmias, *Amer. J. Med. 37,* 670, (Nov) 1964.
4. Singer, D. H., and Ten Eick, R. E., Pharmacology of cardiac arrhythmias, *Prog. in Cardiov. Dis. 11,* 488, (May) 1969.
5. Lieberman, N. A., Harris, R. S., and Katz, R. I., The effect of lidocaine on the electrical and mechanical activity of the heart, *Amer. J. Cardiol.,* 22, 375, (Sept) 1968.
6. Galindo, A. H., and Sprouse, J. H., Anesthesia and cardiac excitability produced by single pulsed electrical stimulation. *Anesth. and Analg. 41,* 659, (Nov-Dec) 1962.
7. Boettner, R. B., Dunbar, R. W., and Morrow, D. H., The comparative anti-arrhythmic effects of mepivacaine and lignocaine. In press. *Brit. J. Anesthesia,* 42, 685, (Aug) 1970.
8. Harrison, D. C., Sprouse, J. H., and Morrow, A. G., The anti-arrhythmic properties of lidocaine and procaine amide: clinical and physiological studies of the cardiovascular effects in man, *Circulation, 28,* 375, (Sept) 1968.
9 Jorfeldt, L., Lofstrom, B., and Pernow, B. The effect of local anesthetics on the central circulation and respiration in man and dogs. *Acta. Anaesth. Scandinav. 12,* 153, 1968.
10. Kao, F. F., and Ulla, H. J. The central action of lignocaine and its effect on cardiac output, *Brit. J. Pharmacol. 14,* 522 (Dec), 1959.
11. Bonica, John J.-Personal Communication.

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In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in the Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

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Treatment of Diabetic Retinopathy by Photocoagulation†

PATRICK R. O'CONNOR, M.D.

Louisville, Kentucky

Photocoagulation offers to a large group a simple and apparently effective means to alter the progression of diabetic retinopathy. Early detection and treatment, augmented by the management of vitreous hemorrhage, provides the best ocular prognosis.

Diabetic ocular disease is the second most common cause of blindness in the United States. Eighty-four per cent of the visual loss among diabetics can be attributed directly to retinopathy. Strict medical diabetic control seems to delay the onset of the retinal vascular changes, the earliest phase of retinopathy. Once diabetic proliferative disease is noted, ocular deterioration is rapid, and on the average, leads to blindness in six to eight years. Pituitary ablation has salvaged numerous eyes, but its widespread use has been limited by selection criteria as well as operative morbidity. Early studies indicate that photocoagulation of diabetic retinopathy is applicable to a much larger group, achieves equally good results, and avoids the hospital confinement and close medical supervision which follows hypophysectomy.

The past several years have witnessed abrupt changes in the treatment of diabetic retinopathy. This paper describes these changes and the results of photocoagulation as a means to alter the progression of diabetic retinopathy.

Davis, Fine, Goldberg, McMeel, Norton, Okun, and Wetzig devised the "O'Hare" Classification of diabetic eyes in 1968 (Table 1). In this classification, background retinopathy characterized all degrees of diabetic retinal disease, excluding proliferative changes. The degree of neovascularization, vitreous hemorrhage, and fibrous growth defined the proliferative changes (Fig. 1). Its use is recommended as a guide in evaluating diabetic retinopathy.

TABLE 1

O'Hare Classification of Diabetic Retinopathy

B.	Background retinopathy—this category includes patients with all degrees of diabetic retinopathy excluding proliferative changes.
H_0.	No vitreous hemorrhage.
H_1.	Presence of vitreous hemorrhage, but the retina can be seen well enough to be classified.
H_2.	This category describes eyes with a vitreous hemorrhage which is so extensive that the retina cannot be seen well enough to be classified.
N_1.	Four of fewer discrete patches or four of fewer disc areas of new vessels.
N_2.	Greater than four discrete patches or greater than four disc areas of new vessels.
F_0.	No fibrous proliferation extending into the vitreous cavity.
F_1.	Fibrous proliferation extends into the vitreous cavity, but involves four or fewer discrete patches or four or fewer disc areas.
F_2.	Greater than four discrete patches or greater than four areas of fibrous proliferation extending into the vitreous.

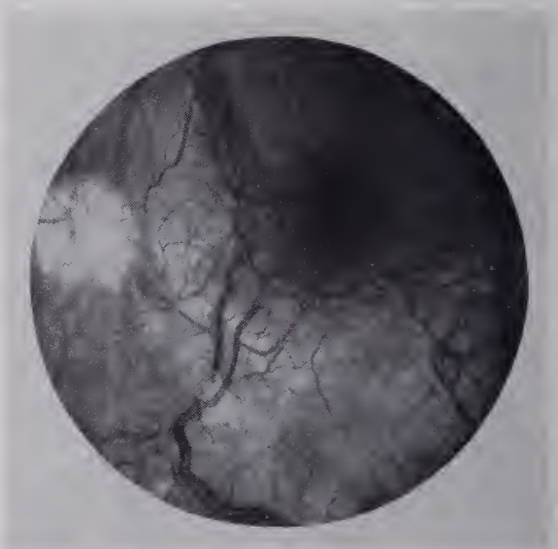


Fig. 1 An example of extensive surface neovascularization and fibrous proliferation without vitreous hemorrhage (O'Hare Classification = $N_2F_1H_0$).

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Clinical examination and histologic studies support the interpretation that the course of diabetic retinopathy can best be viewed as a gradually increasing ischemia from obliteration and narrowing of the retinal capillaries.[1] The role played by shunt vessels and microaneurysm formation in the development of this ischemia remains to be determined. The presence of living tissue, low oxygen tension, and poor venous drainage stimulate neovascularization. Vitreous contraction draws these vessels and the surrounding retina forward, resulting in vitreous hemorrhage and retinal detachment. Photocoagulation can alter this sequence by (a) improving the overall retinal metabolism by elimination of zones with borderline nutritional supply, (b) reducing the incidence of vitreous hemorrhage and induced proliferative growth by destroying areas of neovascularization, and (c) surrounding localized areas of proliferans to form a barrier which resists vitreous contraction and may abort the development of retinal detachment.[2] Eyes not amenable to treatment by photocoagulation include those with neovascularization of the disc, total retinal detachment, diffuse vitreous hemorrhage, and neovascularization within the vitreous cavity.

An aggressive approach to diabetic retinopathy was formulated in 1967 by Cornell Medical Center. Similar methods are now used by the University of Louisville. The photocoagulation technique employs the Xenon arch photocoagulator, retrobulbar anesthesia, and light applications using the 1.5° and 3° apertures. All areas of vascular disturbance are destroyed—microaneurysms, neovascularization, peripapillary vessels, vascular tufts and fans. One hundred to 200 applications are produced at each session, and 600-800 applications are frequently required to arrest the disease.

Initially, patients were bilaterally patched and hospitalized several days following treatment. Experience proved these precautions conservative and unnecessary. Out-patient photocoagulation combined with restrictive activity for one week is an acceptable alternative.

Complications were uncommon. Excessive photocoagulation at the base of severe proliferans with marked vitreous traction, especially if located posteriorly, may occasionally initiate retinal tearing. Hemorrhage from photocoagulation was rare and always small. There were no cases of accidental macular loss from photocoagulation in this series. Excessive widespread treatment may produce a choroidal and exudative retinal detachment which resolves without residual effect in one to two weeks. Field loss was remarkably little and usually limited to scattered scotoma, though an occasional patient experienced a sector defect.

Photocoagulation usually results in major changes in the appearance of the fundus. Microaneurysms and capillary dilations disappear after coagulation; venous distention decreases; retinal edema and hard exudates slowly disappear; and neovascularization ceases (Fig. 2).

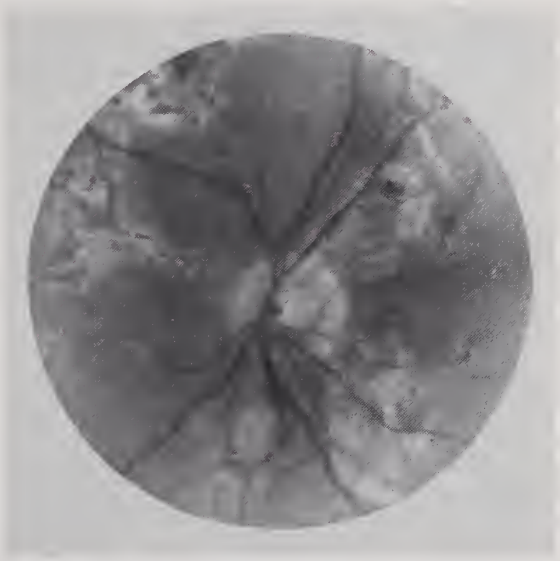


Fig. 2 Fundus appearance six weeks after extensive photocoagulation for diabetic retinopathy.

Vitreous hemorrhage is the single most destructive event in the course of diabetic retinopathy. Its presence stimulates vitreous syneresis and contraction which enhances proliferans and may lead to retinal detachment. Experience in the management of vitreous hemorrhage from acute retinal tearing with or without detachment can be applied to diabetic cases. Initially all such hemorrhages are usually confined to the retrovitreal space in front of the retina. Prompt bilateral ocular patching combined with head elevation allows the blood to pool inferiorly and slowly absorb.[3] This form of prophylactic management must be continued until photocoagulation is completed and most of the blood has

VISUAL ACUITY AFTER THERAPY

		RETINOPATHY PRIOR TO TREATMENT		
		HEMORRHAGES AND EXUDATES	SURFACE NEOVASCULARIZATION	RETINITIS PROLIFERANS
IMPROVED	81%	–	4	–
UNCHANGED		–	14	8
DIMINISHED	19%	1	2	3
TOTAL: 32		1	20	11

Fig. 3 Results of treatment in 32 patients followed for six or more months after photocoagulation.

cleared. Once blood-vitreous mixing has occurred, patching and elevation will not usually separate the two. The rapid clearing of hemorrhage in the retrovitreal space provides a means to drastically reduce the morbidity of retinopathy and maintains a clear media for photocoagulation.

During 1967-1968, 32 eyes in 28 patients were selected for photocoagulation, and subsequently followed from six to 30 months (Fig. 3). Twenty-six of these patients had had a major vitreous hemorrhage in the other eye. Sixteen had a recent hemorrhage in the good eye, 11 had retinitis proliferans, 20 had surface neovascularization, and all had multiple visible aneurysms in excess of 50. Following coagulation, 26 of 32 eyes (81 per cent) had the same or better visual acuity at the end of six months and are regarded as stabilized. Six patients (19 per cent) lost some degree of central vision. Three of these had moderately severe proliferative disease.

It is apparent that the selection of suitable candidates for photocoagulation is critical. Patients with only background retinopathy have a relatively good prognosis without treatment. Of those with good initial visual acuity, 51.5 per cent remain stable when followed for five years, 34 per cent become moderately impaired, and only 14.5 per cent develop blindness.[4] Since progression is usually slow, photocoagulation can be withheld but periodically reconsidered. In patients with well developed retinopathy and severe proliferans, photocoagulation is of questionable value, complications more common and the visual results poor. Patients with surface neovascularization form an intermediate group (Fig. 4). Without photocoagulation the prognosis for visual retention is reduced. The majority will develop a significant vitreous hemorrhage in one year and 50 per cent will become blind in five years. When photocoagulation is limited to those with surface neovascularization, stability or retinopathy can be achieved. However, any degree of vitreous fibrovascular tissue increases the ocular morbidity for these eyes. In a patient with background retinopathy, the development of a large retinal or preretinal hemorrhage, or a vitreous hemorrhage, usually indicates undetected new vessel growth. Hemorrhage and surface neovascularization become synonymous and constitute the earliest signs which suggest consideration of photocoagulation as a means of therapy.

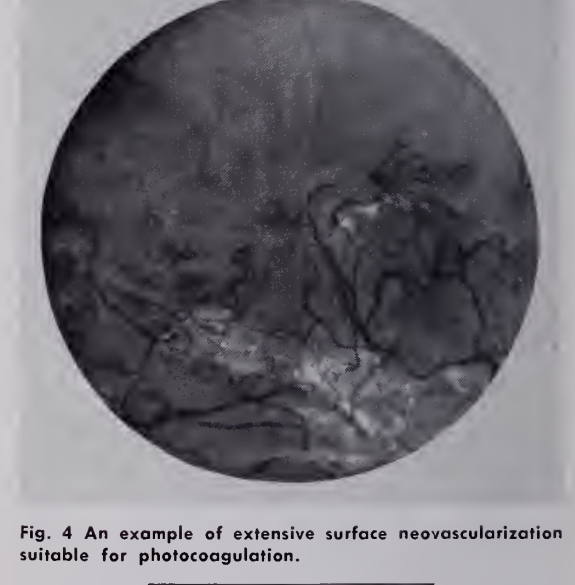


Fig. 4 An example of extensive surface neovascularization suitable for photocoagulation.

Essentially, similar therapeutic results have been reported from other medical centers.[5, 6] Unfortunately, the majority of these surveys, including Cornell's, relied heavily on clinical interpretation as to stability or progression. Only Okun's series of 50 patients attempted to utilize a specific classification and a control group to obtain significant clinical data. He found less progression of proliferative diabetic retinopathy in 80 per cent of the treated group as compared to 58 per cent in the control group.[7] Using the "O'Hare" Classification, a retrospectic analysis of all cases

(Continued on Page 760)

Neuroblastoma, a Study of Presenting Signs and Symptoms †

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Childhood neuroblastoma can simulate many different diseases, and presents in a surprising variety of ways. The signs and symptoms causing 54 children to seek medical help are analyzed.

Neuroblastoma is one of the most common malignancies of childhood. Most recent reviews of this disease stress its treatment, prognosis and complications.[1-4] In reviewing the patients with neuroblastoma at the Children's Hospital, the variety of presenting symptoms was surprising. The causes for which the patient first sought medical advice were protean in nature. The first diagnosis proposed was frequently far removed from the ultimate diagnosis of neuroblastoma.

The remarkable variability of the presentation of leukemia in childhood is well known, but similar diversity in the presenting complaints of neuroblastoma has not been emphasized.

Material: Fifty-four patients' records with proven disease were available for analysis during the past 19 years. The first presenting complaint which caused the patient to seek medical attention is listed. Most patients first sought medical attention from their private physicians, though a few first appeared at one of the clinics in Children's Hospital. Patients from this area were first hospitalized here, but others were frequently hospitalized elsewhere before transfer to this hospital for diagnosis and definitive therapy.

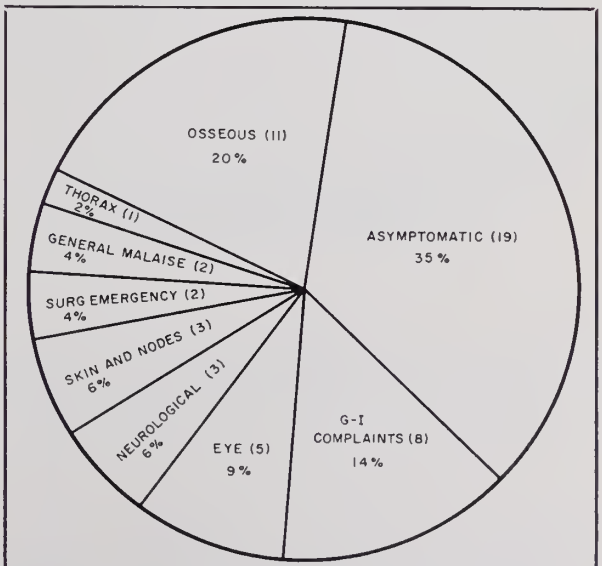
Findings: In 17 patients there was no related complaint, a mass being palpated on routine examination by the attending physician. The reason for medical advice at this time was either a routine physical examination or a complaint completely unassociated with the mass. In two cases masses were palpated by the patient's parents.

In 11 patients the presenting complaint was pain specifically referable to the bones or joints. In several patients in whom the x-rays were normal at this time, the diagnosis was thought to be one of the rheumatic diseases.

Eight patients had gastrointestinal symptoms. Diarrhea, probably related to the catecholamine break-down products,[5] was present in three of these patients. Jaundice was the presenting complaint in one other patient in this group.

Five patients presented with eye signs or symptoms. Four of these had the well recognized bilateral proptosis with black eyes. One patient presented with Horner's syndrome.

Three patients first appeared with signs and symptoms of spinal cord tumor.



PRESENTING SYMPTOMS IN FIFTY-FOUR PATIENTS WITH NEUROBLASTOMA

†*From the combined Pediatric Hematology-Oncology Clinic, The Children's Hospital, Louisville, Kentucky and the Departments of Radiology, Pathology, and Surgery, the University of Louisville Medical School, Louisville, Kentucky*

One patient was referred because of respiratory difficulty thought to be a chronic empyema.

Three patients presented with skin or lymph node manifestations.

Two children appeared with "acute surgical emergencies." One was thought to have had an acute intussusception, and the other was explored for acute appendicitis (Fig.1).

Comments: The marked variability of presenting symptoms relates to the fact that neuroblastoma metastasizes to so many widely separated systems of the body. The chemical activity of the tumor also can initiate symptoms.

At the present time at the Children's Hospital, in any child suspected of having neuroblastoma, the following diagnostic procedures are obtained: 1.) radiological bone survey, 2.) excretory urogram, 3.) chest x-ray, 4.) bone marrow smear, 5.) urinary catecholamine assay, and 6.) when appropriate, a liver scan and/or a selective arteriogram.

Children with single suspicious bone lesions should always be examined for additional lesions, and this lesion should never be biopsied unless metastatic bone disease can be reasonably excluded. The diagnosis can be more simply and safely established by other means.

All children with an undetermined mass should have an urinary catecholamine examination. All patients with lesions involving the spinal cord should be examined for neuroblastoma before the cord lesion can be considered primary and biopsied.

Typical Cases

T. B., 19 months. She had been limping for several days and an x-ray of the extremity at this time was normal. The limping persisted and on further x-ray examination there was a lesion in the proximal tibia. This was biopsied without further investigation and proved to be metastatic neuroblastoma. An excretory urogram made following surgery showed an abdominal mass and the urinary catecholamines were elevated. Unfortunately, the patient fractured completely through the biopsy site. Pain in this area was so great that casting was required until she died several months later. Other metastatic sites were present on a bone survey obtained immediately following the open biopsy.

T. A., 2 months. This patient had a flaccid paralysis of the legs and at myelography there was a block in the spinal subarachnoid space in the thoracic area. The diagnosis was established following laminectomy and biopsy. Following surgery, an excretory urogram outlined a retroperitoneal extension of the tumor and the urinary catecholomines were elevated. The exploration of the spinal canal might have been unnecessary if the diagnosis had been established by other means.

S.H., 7 months. This child had been born with a diaphragmatic hernia which had been repaired, but had recurred. Three surgical procedures on the chest and abdomen were required in all for correction of the hernia. A mass was palpated in the abdomen during the third exploration. A gastrointestinal examination following this outlined a well-circumscribed mass in the duodenal loop which was thought to be a pancreatic cyst. Because of the multiple procedures and the patient's condition, no further investigation was done, though a routine urinary catecholamine test was requested. Surprisingly, this was strongly positive and the neuroblastoma arising posteriorly and intruding in the duodenal loop was successfully excised.

K. H. This five year-old female was admitted for neurological investigation because a "bruit" was thought to be present in her neck. On examination, her eyes were bulging slightly and there was some slight peri-orbital echymosis. There were abnormal cells on the bone marrow smear; there were multiple areas of bone metastases and a primary adrenal mass was outlined on excretory urogram. The urinary catecholamines were positive.

Summary

The presenting signs and symptoms in 54 patients with childhood neuroblastoma have been analyzed.

Practically all organ systems are represented, either due to a primary tumor mass, metastases or the biochemical activity of the tumor.

(Continued on Page 760)



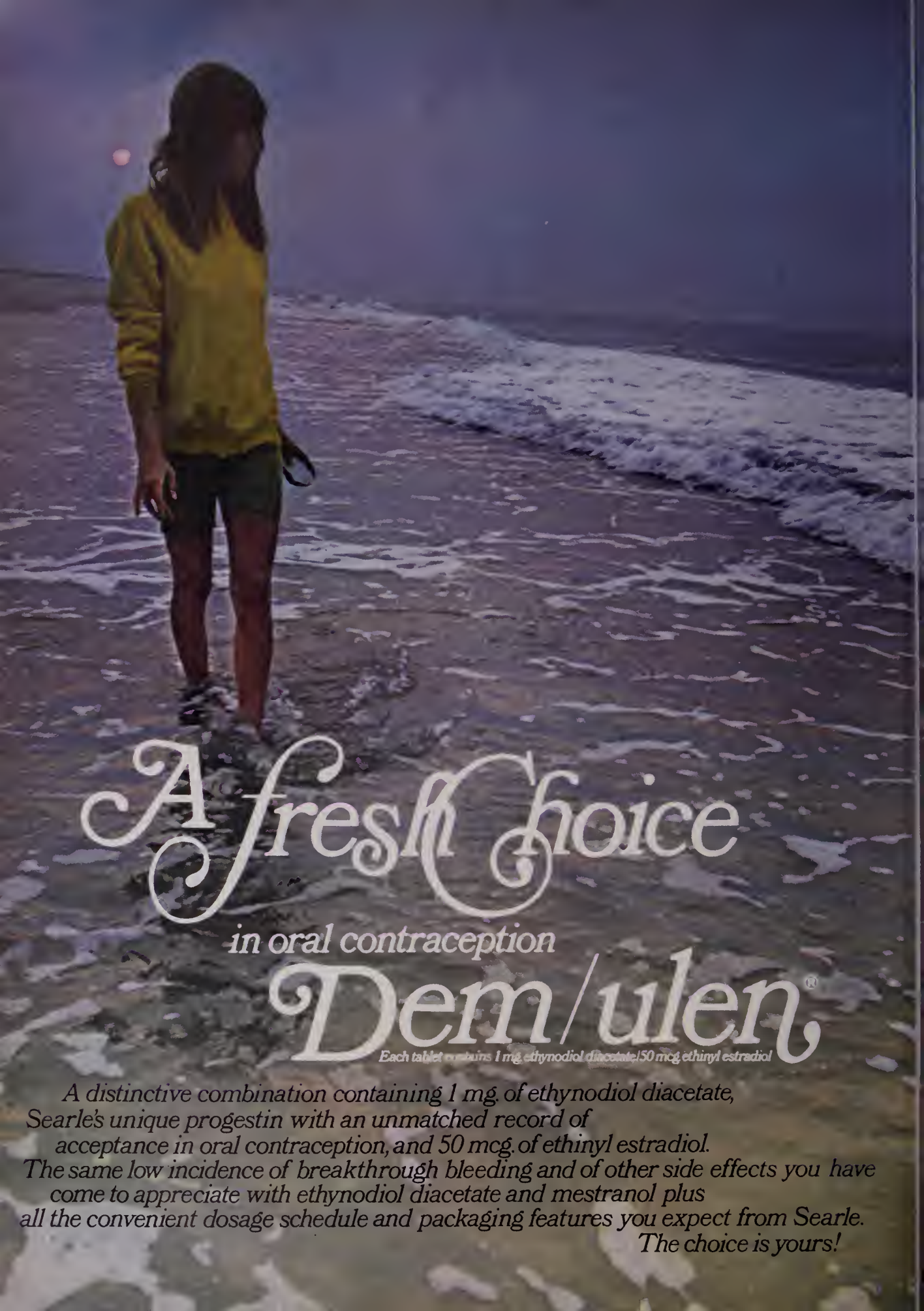
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Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

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Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision. Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.



Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*: 267-279 (May) 1967. *2.* Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. *3.* Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. *4.* Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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SPECIAL ARTICLES

Tell It Like It Is Doctor!
A Discussion of Reasonable Medical Probability in Kentucky†

Joe C. Savage*

FOR several months following an automobile accident, your client complains of headaches, dizziness, vertigo, some nausea and occasional difficulty in properly focusing his eyes. He tells you that although the collision resulted in only minor property damage to the vehicles involved, his head struck the windshield, and that this was the cause of his symptoms. He has not seen a physician. How are you going to prove that the blow to your client's head is the direct and proximate cause of his complaints? Do you need medical testimony? If so, how sure of his opinion must your medical witness be (1) before he is allowed to give it and (2) before you have met your burden of proof on this issue of causation?

You are defending against a plaintiff who alleges to have suffered a ruptured intervetebral disk in the cervical area at the C-6, C-7 interspace, causing severe neck pain and radiating left arm pain, as a result of being rear-ended by your client's insured. You know the plaintiff is forty-five years old and suspect that this neck and arm pain was caused not by the accident but by degenerative arthritis, which is common to persons of this age and which can easily produce these same symptoms. What kind of evidence must plaintiff's counsel offer to establish a direct casual relationship between the accident and the ruptured disc?

As attorney for the widow and four children of a forty-two year old carpenter who suffered a fatal heart attack at work, you would like to obtain maximum death benefits under workmen's compensation. How do you prove that the heart attack was work connected?

A woman claims to have swallowed pieces of glass while drinking a coke, and now complains of all types of bizarre symptoms. How do you prepare to defend such a claim?

A twenty-three year old boy is knocked from his motorcycle, suffering minor fractures and the usual bumps and bruises. Three months later, diabetes mellitus is diagnosed. Can you prove a causal relationship?

Turning for a moment from the problem of causation, what about the problem of future damages? Suppose, at trial, you prove that your client, a twenty year old boy, suffered a closed head injury. Your neurosurgeon is prepared to testify that statistics show that this boy has a five per cent chance of suffering from epilepsy at some time in the future. Can you get such testimony in? Assuming that this is all the testimony on future medical problems, can you get an instruction on future pain and suffering and loss of earning capacity?

Suppose your client, at the time of trial, continues to suffer low back pain, and his treating doctor is prepared to testify that such pain will likely continue, and that the best way to relieve it would be to perform disc surgery and fuse the vertebrae. Is such testimony too speculative? Can you get instructions on medical and doctor bills, future pain and suffering, and loss of earning capacity?

A doctor testifies that he cannot be absolutely sure of anything in medicine, but that its "possible" that plaintiff will never be able to go back to work. Too speculative?

How can the attorney chart his way through such a rough and uncertain wilderness? What are the rules?

What After All, Must The Plaintiff Prove?

In any personal injury negligence action, the plaintiff, to win, must establish by the preponderance of the evidence:

1. A duty on the part of the defendant,
2. A breach of that duty,
3. A direct and proximate causal relationship between breach and injury suffered, and
4. Injury or damage.

Concerning duty, the plaintiff must produce evidence which will establish a duty on the part of the defendant to act as the reasonably prudent person in same or similar circumstances. Concerning breach, the plaintiff must produce evidence which will establish that the defendant did not conform to this reasonable man standard. For the purposes of this paper, we may assume that both duty and breach have been established.

Concerning causation, the plaintiff must produce evidence which will establish that the injuries for which the plaintiff asks to be compensated were

†*Reprinted from Kentucky Law Journal, Volume 58, 1969-70, Number 3.*

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caused, directly and proximately, by the defendant's breach of duty. What type of evidence must this be, and how persuasive must it be to warrant an instruction on defendant's basic liability?

Concerning injury or damage, the plaintiff, at the time of trial, must produce evidence which will establish any one or more of six possible elements of damage:

1. Past medical expenses,[1]
2. Past earnings lost,[2]
3. Past pain and suffering,[3]
4. Future medical expenses,[4]
5. Future loss of earning capacity, and[5]
6. Future pain and suffering.[6]

Presenting evidence to prove the first three should cause little difficulty. But what type of evidence must be presented and how persuasive must it be to warrant an instruction on the latter three?

Turning for a moment from a personal injury negligence action, what must a plaintiff establish to justify an award in workmen's compensation? He must prove:

1. The employer and employee were under the act,
2. Injury, and
3. The injury arose out of and in the course of his employment.

As in a personal injury case, then, a workmen's compensation plaintiff must establish causation by showing that his injury was work connected. He also must present evidence on future injury if he is to obtain an award for permanent disability.

Through this article, then, we are talking about two distinct problems:

(1) Proof of causation from the breach of duty (personal injury case) or the work duties (compensation case) to the injury, and
(2) The injury now having been established, proof of its future consequence and duration.

The Medical Expert

As will be discussed later, the proof of causation and the proof of future injury usually involve testimony offered in court, or in a deposition, by a medical doctor. Too often this testimony is vague, uncertain and confusing.

One doctor says this or that "could" happen. Another says it "would." Another says "maybe," or "possible." Still a third says it's "likely."

"I would expect to see" such a result. "I can't be sure, but this can happen." "This may happen, if . . . ." "These symptoms are consistent with" a particular type of trauma.

One doctor's "could" is another's "would." Two doctors have the same opinion, yet one expresses it in terms of "possibility," the other "probability."

What is the nature of medical testimony that it should be so difficult to express? Must we forever be wary of this quagmire of semantics?

We have all heard it said that "medicine is not an exact science." Some assert that it is not a science at all, but only an art. What label is used is unimportant; the understanding and appreciation the lawyer has of the basic nature of medical knowledge is all important.

The touchstone of medical knowledge is the *opinion* of the doctor. Everything else is subservient. Medical history, physical examinations, X-rays, laboratory procedures, special diagnostic tests—all are merely steps taken along the way by the doctor so that he can finally reach a medical opinion.[7]

Of course, opinions are not absolute facts. This means that no doctor can testify with absolute certainty, and that there are few, if any, areas of medicine free of conflicting opinions. The human body being the complex mechanism that it is, medical knowledge is and will probably continue to be unsettled. Lawyers will forever be exposed to the "educated medical guess."

So when a doctor testifies, all he can bring to court is what he has—his opinion. The attorney should not demand more from his medical witness than he can give. Neither should the court.

Causation—"Etiology"

What evidence must the plaintiff introduce to sustain his burden of proof on the issue of whether the defendant's breach of duty was the direct and proximate cause of plaintiff's injury? Or, if in workmen's compensation, whether the injury was work connected?

The study of the causes of injury or disease in medicine is known as "etiology." What the attorney is really trying to prove, then, is the etiology of his client's injury. Thus, in the hypothetical fact situations posed at the beginning, did the trauma suffered by the plaintiff in an automobile accident cause headaches, nausea and dizziness? Did the stress of work cause a heart attack? Can trauma cause diabetes?

Etiology of injury is a medical issue, and usually must be proven by a medical witness. This is true because only a physician has the knowledge and expertise to make inferences and draw conclusions, hence give an opinion, from medical facts.

But, you say, it takes no medical genius to know that the plaintiff's lascerations of the face were caused by his going through the windshield. And, of course, you are correct. Where the cause of injury is obvious to the layman, medical testimony on causation is not required.

The Court of Appeals has long recognized these doctrines. The most recent example is *Tatham v. Palmer*.[8] In that case, the plaintiff, an eighteen year old boy, suffered headaches after striking his head against the windshield. Without medical testimony, the Court held that the plaintiff's burden of proof on causation had been met.[9] The Court pointed out that circumstantial evidence may be sufficient in some cases to prove causation. "[I]t is within the realm of common knowledge that a severe blow to the head will cause headaches . . . ."[10] The test is, then, what is within the realm of common knowledge.

But what is within such realm has been more

obvious to the Court than it has to me on several occasions. The Court once held, for example, in *Cumberland Railroad Company v. Baird,*[11] that a woman's testimony that she suffered a miscarriage after falling off a horse when it stumbled at a defective railroad crossing was sufficient, without medical testimony, to establish causation. At least two obstetrics and gynecology specialists have told me that it is extremely unlikely that such trauma would produce such a result.

Of course, taking a plaintiff's case to court without medical testimony would be foolish, and, as a practical matter, seldom occurs. The real question, then, is not whether medical testimony is needed, but rather, whether the medical testimony given is sufficient to prove causation? Or, to state it from a different frame of reference, how certain must the doctor be of his opinion in order for the plaintiff to establish causation?

There is one old Kentucky case which infers that the doctor need only testify that the injury "could" have been caused by the trauma. In *Louisville and Nashville Railroad Company v. Braymer,*[12] the issue was whether Braymer's abdominal tumor was caused by his striking his stomach on the seat in front when the train lurched unexpectedly. Plaintiff's medical testimony was, "It could have." The Court held this was sufficient medical proof.

Plaintiff's counsel can take little comfort from this antique, however. Kentucky law for many years thereafter ignored this decision and held that the doctor must testify on causation with "reasonable probability." As with other concepts of negligence, such as duty and breach, causation must be proven by the preponderance of evidence. It must, then, be probable.

Southern Mining Company v. Cornelius,[13] for example, held that plaintiff's medical testimony, to the effect that the plaintiff's hearing loss "could" have been caused by defendant's explosion, was too speculative and would not meet plaintiff's burden on causation.[14]

Jarboe v. Harting[15] presents a classic discussion of causation. In *Jarboe,* a malpractice case, plaintiff's medical testimony that the operation "could" have caused her miscarriage was held not sufficient. It is interesting to further note that the court also held in *Jarboe* that causation could not be established without medical evidence because the cause of this miscarriage was not "so apparent that laymen with a general knowledge would have no difficulty in recognizing it."[16] Evidently, the miscarriage in *Jarboe* wasn't as obvious as the miscarriage in *Baird.*

Bartley v. Childers[17] is the last case I can find on this issue. A wrongful death case, *Bartley* holds that medical testimony that death "most likely" was caused by asphyxiation by drowning satisfies the probability rule. The Court suggested that all that is required is that the testimony be strong enough to warrant "an inference of causation," as opposed to speculation, surmise or guesswork. After noting that the line between what is speculative proof and what is circumstantial or inferential proof is sometimes dim and uncertain, the Court quoted from *Highway Transport Company v. Daniel Baker Company*[18] that the plaintiff's burden is to " 'introduce sufficient proof to tilt the balance from possibility to probability.' "[19]

Workmen's compensation law has had the probability rule on causation for some time. The doctor testifying that the trauma at work "would" or "probably" cause the injury satisfied this rule. "Could" or "possibly," however, did not.

The heart attack cases in workmen's compensation have been particularly troublesome. With almost the same set of facts, cases have gone both for and against the plaintiff, depending upon the language of the testifying doctors. Thus in *Terry v. Associated Stone Company,*[20] and in *Grimes v. Goodlett and Adams,*[21] the doctors testified that the stress at work precipitated the attack, or that the causation was reasonably probable, so the plaintiffs won. In *Dupriest v. Tecon Corporation*[22] and *Kelly Contracting Company v. Robinson,*[23] the medical testimony on causation was only that such an attack was "possibly" a result of stress at work, so the plaintiffs lost.

Perhaps the highwater mark in the probability rule in causation cases came with *Inland Steel Company v. Johnson,*[24] a 1969 case. Also a workmen's compensation heart attack case, dictum suggests that even if the doctor uses the word "possible," his testimony should not, therefore, be discounted, but should be examined carefully from start to finish, within the total context of his testimony, to determine whether he really meant "probable." The Court cited McNiece, Heart Disease and the Law (Prentice-Hall, Inc. 1961) at page 136,

> Physicians differ in the degree of caution or lack of caution with which they phrase their opinions, and one man's 'possibility' may be equivalent to another's 'probability.' It is submitted that, except where the use of the term 'possibility,' or other words of similar import, is indicative of an over-all viewpoint, the mere employment of such language should not be, as it is in some states, a basis for disregarding the particular physician's testimony. Substance should prevail over form, and the experts' testimony should be examined in its total meaning, rather than word by word.[25]

So "probability" is the test. Even "possibility" will not be held insufficient on its face, but will be examined to see if "probable" was really intended.

But there are still too many questions unanswered. What is probability? It has never been defined. Is it a chance? A better than even chance? More likely than not? 51-49? 75-25?

I submit that probability in the area of causation should mean "more likely than not." After all, the plaintiff's burden is only to establish his case by the preponderance of the evidence. Testimony that it is more likely than not that a particular breach of duty caused this injury would be a preponderance.

Future Damages—"Prognosis"

Future damages, that is, future medical expenses, loss of earning capacity and future pain and suffering involve a prediction of the future medical

course of the patient. This, in medical jargon, is "prognosis." What evidence must the plaintiff introduce to sustain his burden of proof if he is to get an instruction authorizing recovery for these future damages?

As with causation, prognosis is a medical issue and usually must be proven by a medical witness. Also, as in causation, however, where it is within the realm of common knowledge that a person will continue to incur these future damages, medical testimony is not required.

Thus, concerning future pain and suffering, where it is fairly obvious that a person will continue to suffer pain after the trial, medical testimony on future pain and suffering is not required.[26] Whether medical testimony is necessary depends to a large extent on the nature of the injury involved.

Concerning future loss of earning capacity, the same rule applies. In *Smith v. Hamm*,[27] the Court held that testimony of the loss of an important organ (spleen) was sufficient to warrant a finding of permanent injury and an award for damages, therefore without medical testimony.

Concerning future medical expense, I could find no cases, but would think that the same rule applies.

Again, as in the area of causation, to take to trial a personal injury case without medical testimony on future damages would be foolish. So the practical question, again, is not whether medical testimony is necessary, but rather, whether the medical testimony is sufficient to prove these damages.

Rogers v. Sullivan[28] changed prior case law in this area of prognosis. The Court had previously held in *Ingram v. Galliher*,[29]

> It is an established rule that to warrant recovery for permanent injuries, the future effect of the injuries sustained must be shown with reasonable certainty. The evidence must be positive and satisfactory, although it need not conclusively show the condition to be permanent. So, a mere conjecture or even probability of lasting disability does not warrant recovery for permanent impairment of earning power.[30]

As late as 1966, the Court in *Townsend v. Stamper*[31] held similarly as in *Ingram*.

Rogers overrules such nonsense. As Judge Palmore points out[32] in that opinion, all we are talking about is damages and in order to obtain an instruction authorizing recovery for damages, the fact of damages must be taken out of the area of speculation. This is the rule generally applicable to proof of compensatory damages; it is not peculiar to personal injury cases. Where damages are too specualtive, they should not be allowed. Judge Palmore then relates probability to speculation, holding that testimony of "probable" future damages removes the fact of damage from the area of speculation and warrants an instruction.

Rogers has been followed once, in *Jones v. Skiles*.[33] The case will probably be cited for a long time. But *Rogers* is important from still another viewpoint. Possibility, probability and certainty have long confused lawyers in the phrasing of their questions to the medical witness. To remove such semantic stumbling blocks, Judge Palmore wrote,

> It seems to us that it would be proper simply to ask the witness for his opinion as to the prospects of recovery, and let him explain as he wishes. [citations omitted] The thing that counts is what he says; the question need only open the subject.[34]

This is important, then, because the doctor can testify as to prognosis any way he sees fit, even if he feels there is only a "possibility" of future damage. And the question which opens up this topic need not contain the phrase "based on reasonable medical probability," or anything else.

The rule seems to be, then, that in order to get an instruction on future damages, probability of such damage is required; to get testimony from the doctor, the question need not call for an opinion based on probability. All the doctor need to do is "tell it like it is."

What does "probable" mean in this area of future damage? The term has never been defined in this area either. Should it mean the same as in the area of causation? The Court in *Rogers* only intended that future damages not be speculative. It then adopted "probability" as the test of speculation, without defining probability.

If we define probability as "more likely than not," as I suggested we do in questions of causation, do we automatically conclude that anything short of this is too speculative? This may sound good in theory, but consider again the hypotheticals posed in the beginning. Is a five per cent certainty of epilepsy at some time in the future a probable future injury? Too specualtive? Would you require a higher percentage?

Neurosurgeons will tell you that the percentage of patients developing epilepsy at some later time substantially increases with the severity of the head injury. With an open head injury, for example, the percentage climbs to fifty per cent or even higher. Is a forty-nine per cent or even a fifty per cent certainty of epilepsy a probable future injury?

If you were the five per cent patient seeking redress in court, wouldn't you want the jury to hear this evidence? Wouldn't you want an instruction on future pain and suffering and on loss of earning capacity? Is it fair to require you to be in the fifty-one per cent or better range to obtain relief?

Prognosis in medicine is probably the least certain of all areas. Will I need another operation? Will I ever be able to walk? Will I regain my sight? Will I return to manual labor? All these questions are, to some extent, speculative in nature. The answers are based upon past statistical experience applied to the present condition of the patient. Is it fair to the patient to adopt a "more likely than not" rule in this area?

Rogers already stands for the proposition that the doctor need only be asked for a prognosis, and

then he can explain as he wishes. The opinion will, therefore, be before the jury. Why not then give the jury instructions on future damage and let them calculate the plaintiff's chances any way they see fit?

Any Chance To Reopen After Argument?

The fairest solution to this dilemma would be to allow a plaintiff to obtain a new trial on damages should his condition deteriorate. The defendant could do the same thing if the plaintiff got better. Of course, this is done in workmen's compensation quite regularly by a motion to reopen. Is there any authority which would permit such action in a civil case?

Civil Rule 60.02 provides:

> On motion a court may upon such terms as are just, relieve a party or his legal representative from its final judgment, order, or proceeding upon the following grounds: (1) mistake, inadvertance, surprise or excusable neglect; (2) newly discovered evidence which by due diligence could not have been discovered in time to move for a new trial under Rule 59.02; (3) perjury or falsified evidence; (4) fraud affecting the proceedings, other than perjury or falsified evidence; (5) the judgment is void, or has been satisfied, released, or discharged, or a prior judgment upon which it is based has been reversed or otherwise vacated, or it is no longer equitable that the judgment should have prospective application; or (6) any other reason of an extraordinary nature justifying relief. The motion shall be made within a reasonable time, and on grounds (1), (2), and (3) not more than one year after the judgment, order, or proceeding was entered or taken. A motion under this Rule does not affect the finality of a judgment or suspend its operation.[35]

If a plaintiff develops epilepsy twenty years after a judgment is entered, might he be "relieved" of the judgment upon ground (6)? Sounds pretty far-fetched, doesn't it?

In *Anshutz v. Louisville Railway Company*,[36] the defendant was held to be relieved of a final judgment upon the grounds of newly discovered evidence. The plaintiff and two doctors had testified that because of the trauma suffered by the plaintiff, both fallopian tubes and the left and most of the right ovaries were removed, so that the plaintiff was forever barren, and that the trauma had caused a tumor to develop at the site. Several months after trial, long after the time for appeal had run, the tumor became a baby boy!

Anshutz was based on Civil Code, Section 344, the forerunner of CR 60.02. It is one of the few cases I could find setting aside a judgment.

The general rule, however, is that courts do not favor the granting of new trials for newly discovered evidence, particularly evidence tending to prove a change of physical condition of the plaintiff. In *Woods v. Kentucky Traction & Terminal Company*,[37] the plaintiff testified she was paralyzed from traumatic neurosis and recovered $15,000. Naturally the defendant was chagrined when the plaintiff was seen walking shortly after judgment. Without actual proof of fraud, however, the court refused to set aside the judgment, and distinguished *Anshutz* by stating that the plaintiff's testimony in *Anshutz* was so incorrect as to constitute fraud and conspiracy on its face. See also *Teche Lines v. Boyette*,[38] which is a Sixth Circuit federal case similar to *Woods*.

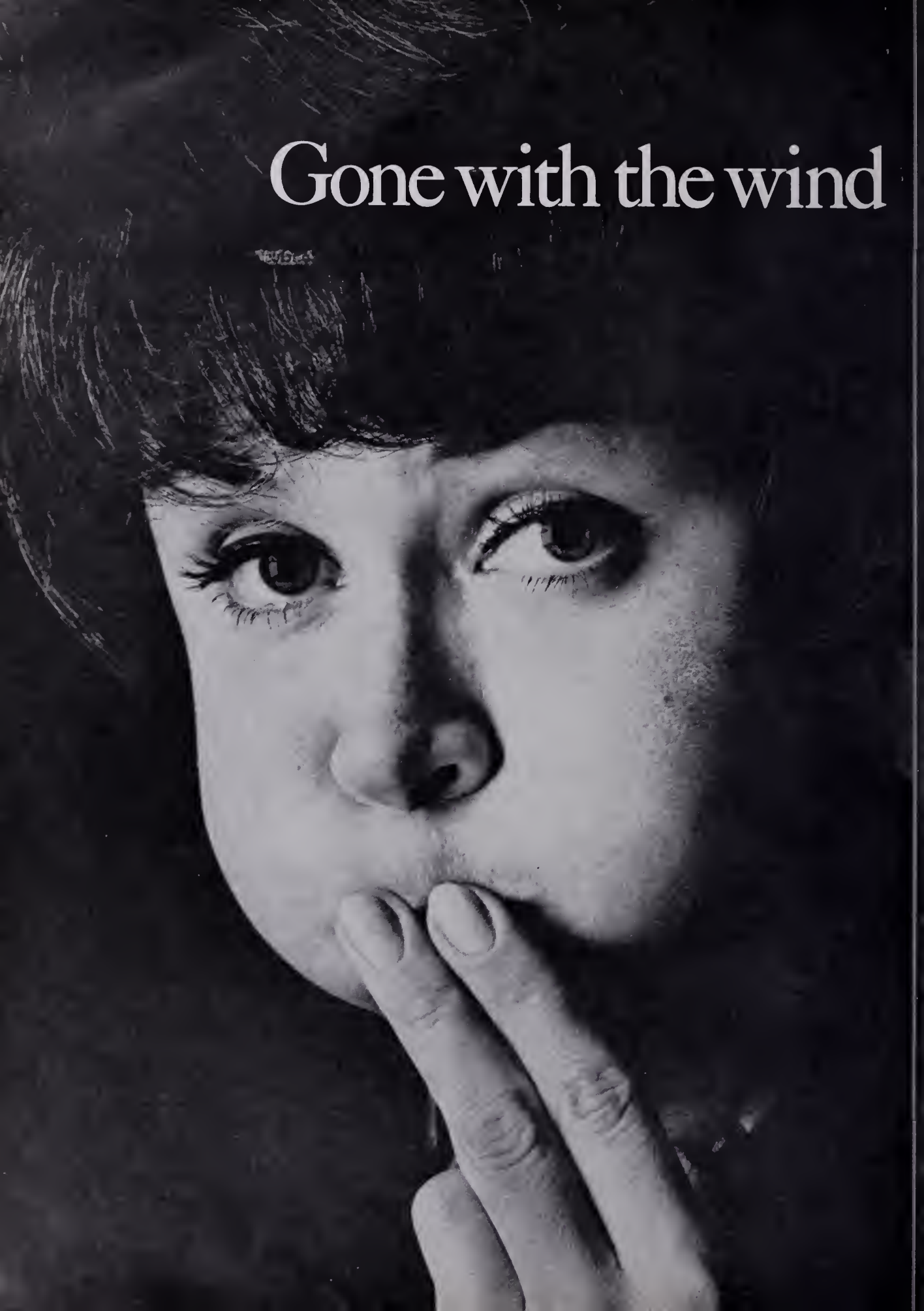
Conclusion

While reasonable medical probability is the test in Kentucky, in both the area of causation and the area of future damage, no cases really define "probability." Evidently, the doctor can testify any way he likes, and his testimony will then be examined in its total context to see whether the probability test has been satisfied. If it has on causation, the plaintiff will get a liability instruction and the case will go to the jury. If it has on future damages, the plaintiff will get instructions on future medical expenses, loss of earning capacity, and future pain and suffering.

If probability be defined as "more likely than not," this would be an acceptable standard in the area of causation but might work hardship in the area of future damage. A possible remedy for such hardship would be to allow the plaintiff to reopen, but Kentucky law at present really precludes this possibility.

References

1. Am. Jur. 2d Damages: 102 (1965).
2. Id.: 90.
3. Id.: 105.
4. Id.: 102.
5. Id.: 92.
6. Id.: 106.
7. M. Howts, *Lawyer's Guide to Medical Proof* (1966).
8. 439 S. W. 2d 938 (Ky. 1969).
9. See also *Jarboe v. Hastings*, 397 S. W. 2d 775 (Ky. 1965); *Johnson v. Vaughn*, 370 S. W. 2d 591 (Ky. 1963).
10. 439 S. W. 2d at 939.
11. 156 Ky. 225, 160 S. W. 919 (1913).
12. 18 Ky. L. Rptr. 1098, 39 S. W. 24 (1897).
13. 284 Ky. 515, 145 S. W. 2d 93 (1940).
14. *Ky. Digest Damages*, Key 185 (1952), contains a list of cases on the issue of sufficiency of evidence on causation in personal injury cases.
15. 397 S.W. 2d 775 (Ky. 1965).
16. Id. at 778.
17. 433 S. W. 2d 130 (Ky. 1968).
18. 398 S. W. 2d 501 (Ky. 1965).
19. 433 S. W. 2d at 132.
20. 334 S. W. 2d 926 (Ky. 1960).
21. 345 S. W. 2d 47 (Ky. 1961).
22. 396 S. W. 2d 778 (Ky. 1965).
23. 377 S. W. 2d 562 (Ky. 1964).
24. 439 S. W. 2d 562 (Ky. 1969).
25. Id. at 563, n. 2.
26. See *Williams v. Kirtley*, 263 S. W. 2d 119 (Ky. 1953).
27. 314 Ky. 339, 235, S. W. 2d 437 (1950).
28. 410 S. W. 2d 624 (Ky. 1967).
29. 309 S. W. 2d 763 (Ky. 1958).
30. Id. at 766-67.
31. 398 S. W. 2d 45 (Ky. 1966).
32. 410 S. W. 2d at 628.
33. 434 S. W. 2d 637 (Ky. 1968).
34. 410 S. W. 2d at 627-28.
35. Ky. R. Civ. P. 60.02.
36. 152 Ky. 741, 154 S. W. 13 (1913).
37. 252 Ky. 78, 65 S. W. 2d 961 (1933).
38. 111 F. 2d 579 (6th Cir. 1940).


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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



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Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

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Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

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Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence: erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions where complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

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ORGANIZATION SECTION

The House Elects Dr. Harter, Dr. Grise At Annual Meeting

John S. Harter, M.D., Louisville, was chosen president-elect of KMA by the House of Delegates for the Associational year of 1970-1971.



Doctor Harter

Also elected at the September 23 session was Richard F. Grise, M.D., Bowling Green, who is the Association's new vice-president.

John C. Quertermous, M.D., Murray, was installed as KMA president at the close of the session. He succeeds Walter L. Cawood, M.D., Ashland.

Doctor Harter has been in private practice in thoracic surgery in Louisville since 1945. He is past president of the Jefferson County Medical Society and of the Southern Thoracic Surgical Association. He is currently serving as clinical professor of thoracic surgery at the University of Louisville School of Medicine.

Succeeding David A. Hull, M.D., Lexington, Doctor Grise was the president of the Kentucky Chapter, College of Surgeons in 1967-68, is a former president of the Kentucky Division of the American Cancer Society and is presently serving on the Board of Directors of that Society. He has been chairman of the Awards Committee of KMA since 1966.



Doctor Grise

Re-elected AMA delegate for the term January, 1971-December, 1972 was J. Thomas Giannini, M.D., Louisville; re-elected alternate delegate was Charles G. Bryant, M.D., Louisville.

1970 KMA Interim Meeting Set For April 15-16

The 1971 Interim Meeting will be held April 15-16 at the Holiday Inn Motel, Cave City, Kentucky.

The KMA Interim Meeting Committee will meet this month to finalize plans for the program. There are facilities at Cave City for work and recreation, and time will be scheduled for both.

An Orientation Program will not be held during the Interim Meeting this year; however, the Woman's Auxiliary to KMA will hold its usual meeting.



Shown immediately following the Wednesday night session of the House of Delegates are: (from left to right) John C. Quertermous, M.D., Murray, president of KMA; Walter L. Cawood, M.D., Ashland, immediate past president; and John S. Harter, M.D., Louisville, president-elect.

Dr. Hess Elected Board Chairman; Vice-Chairman Is Dr. McLeod

Lee C. Hess, M.D., Florence, was elected chairman of the KMA Board of Trustees at its first meeting of the associational year, September 24. Robert N. McLeod, Jr., M.D., Somerset, was chosen vice-chairman of the Board.



Dr. Hess

Doctor Hess, chairman of the KMA Board of Trustees 1968-1969, succeeds William W. Hall, M.D., Owensboro.

A general practitioner, Dr. Hess is a 1956 graduate of the University of Louisville School of Medicine. He has served on the KMA Board of Trustees since 1966, is a member of the Kentucky and American Academies of General Practice and is former treasurer of the Boone County Medical Society.

Succeeding Thornton E. Bryan, M.D., Cadiz, Doctor McLeod has been on the Board of Trustees since 1968. He has served KMA as the chairman of the Committee on Neo-Natal Mortality, on the Board of Consultants on Scientific Articles for *The Journal* and on the committee on School Health, Physical Education and Athletics.



Dr. McLeod

Newly elected trustees are Charles C. Kissinger, M.D., Henderson, Second

District; Thomas P. Leonard, M.D., Frankfort, Seventh District; David A. Hull, M.D., Lexington, Tenth District; J. Wesley Johnson, M.D., Ashland, Thirteenth District. Re-elected to another term as trustee was J. Campbell Cantrill, M.D., Georgetown, Ninth District.

KEMPAC Physicians, Guests Hear Senator, U. S. Representative

Two hundred and fifty physicians and guests heard Senator W. Jennings Randolph, D-West Virginia, and United States Representative Durward G. Hall, M.D., R-Missouri, speak at the Eighth Annual KEMPAC Seminar held September 21 at the Kentucky Hotel. C. Kenneth Peters, M.D., Jeffersontown, KEMPAC chairman, presided.

Both speakers discussed "Physician Involvement in Government and Governmental Involvement in Medicine." Senator Jennings stressed that changes will be made in health insurance programs and that physicians should offer their "advice and counsel" to Congress on this matter.

Representative Hall told his audience that he is drawing up a new health insurance plan. His plan would require the federal government to buy insurance policies for the poor from already established private insurance companies. The state government would assume financial responsibility in castastrophic illnesses.

A highlight of the seminar was the presentation of a gavel to John C. Quertermous, M.D., Murray, the immediate past chairman of KEMPAC.

Auxiliary Installs Mrs. Hornaday, Elects Mrs. Stevens

Mrs. Charles E. Hornaday, Owensboro, was installed as president of the Woman's Auxiliary to KMA during its Annual Convention September 22-24 in Louisville. Mrs. David Stevens, Lexington, was chosen president-elect. Mrs. Hornaday succeeds Mrs. Hoyt D. Gardner, Louisville, who presided at the meeting.



President John C. Quertermous, M.D., Murray, (left) presents a plaque for outstanding service as president of KMA to Walter L. Cawood, M.D., Ashland, immediate past president. The presentation was made at the close of the final session of the House of Delegates, September 23.

Other officers elected during the meeting were Mrs. C. Kenneth Peters, Louisville, 1st vice-president; Mrs. Edwin T. Davis, Paducah, 2nd vice-president; Mrs. Ben Crawford, Lexington, 3rd vice-president. Mrs. James Ferrell, Paris, was re-elected 4th vice-president.

Mrs. James Gulley, Madisonville, was re-elected recording secretary. Mrs. William Pearson, Owensboro, was elected corresponding secretary; Mrs. Leslie Langley, Jr., Elizabethtown, treasurer, and Mrs. J. Murray Kinsman, Louisville, parliamentarian.

The theme of this year's Auxiliary Luncheon was the zodiac. The guest speaker was Rex Kenyon, M.D., Oklahoma City, who spoke on "Medicine's Meteorite, You The Auxiliary."

A highlight of the luncheon was the presentation of the Auxiliary's Health Citation Award to Miss Teresa Goetz, Lexington, for her outstanding contribution in the field of health. Miss Goetz, a retired dietician, experimented in her own kitchen to find a teething biscuit that can be used by children who have a tendency toward PKU.



The officers of the Kentucky Medical Association for 1970-71 (pictured above, from left to right) are: John C. Quertermous, M.D., Murray, president; John S. Harter, M.D., Louisville, president-elect; S. Randolph Scheen, M.D., Louisville, secretary; and Keith P. Smith, M.D., Corbin, treasurer.

Faculty Awards Presented To Drs. Noonan, Christopherson

The 1970 recipients of the KMA Faculty Scientific Awards are Jacqueline A. Noonan, M.D., Lexington, and William M. Christopherson, M.D., Louisville. The awards were presented at the Annual Meeting President's Luncheon September 23.

Established in 1962 by the KMA Committee on Medical Education, the Faculty Scientific Awards are presented each year to a faculty member of each of the two medical schools in Kentucky. The recipient must have done outstanding research or have made a considerable contribution to the field of medicine.

Jacqueline A. Noonan, a pediatrician with a specialty in pediatric cardiology, is active on the clinical faculty of the University of Kentucky Medical School. She is well known for her teaching and writing ability.

William M. Christopherson, professor and chairman of pathology of the University of Louisville School of Medicine since 1956, has served as consultant, author and editor in the field of pathology, especially in cancer.



The 1970 KMA Faculty Scientific Awards were given to Jacqueline A. Noonan, M.D., Lexington, and William M. Christopherson, M.D., Louisville. In the picture above Doctors Noonan and Christopherson are shown with the Awards Committee chairman, Richard F. Grise, M.D., Bowling Green, (center) following the President's Luncheon.

Two Physicians, One Attorney Receive KMA's Top Awards

William R. Willard, M.D., Lexington; Bush A. Hunter, M.D., Lexington, and William M. Grant, Owensboro, received KMA's three top awards this year. The award presentations were made September 23 at the President's Luncheon by Richard F. Grise, M.D., Bowling Green.

The Distinguished Service Award, presented annually to the physician selected as the most outstanding member of the Kentucky Medical Association, went to Dr. Willard. He was one of the prime organizers of the Albert B. Chandler Medical Center complex at the University of Kentucky and was the first dean of the College of Medicine while also serving as vice-president of the Medical Center. He is currently serving as special assistant for health affairs to University of Kentucky president, Otis A. Singletary.



President-elect John S. Harter, M.D., Louisville, (center) is escorted to the speakers platform by past presidents George F. Brockman, M.D., Greenville, (left) and Henry B. Asman, M.D., Louisville, (right) following Doctor Harter's unanimous election.

Dr. Hunter, who has practiced medicine for 43 years in Fayette County, received the Outstanding General Practitioner Award. He was with the Community Health and Welfare Department for ten years and a member of the Public Health Center medical staff for twenty years.

The R. Haynes Barr Award, designed to honor a lay person for outstanding accomplishments in the field of public health and/or medical care, was presented to William M. Gant, an Owensboro attorney. He has been active in the field of drug abuse information in Daviess County.



Chairman of the Board of Trustees, William W. Hall, M.D., Owensboro, (right) administers the oath of office as president of KMA to John C. Quertermous, M.D., Murray, at the final session of the House of Delegates during the 1970 Annual Meeting.



KMA Awards Committee Chairman Richard F. Grise, M.D., Bowling Green, (second from right) is pictured with the recipients of KMA's top three awards for 1970. They are: (left to right) William M. Gant, Owensboro attorney who received the R. Haynes Barr Award for his outstanding contributions as a layman in drug abuse education programs held in the Owensboro and Daviess County schools; Mrs. William R. Willard, Lexington, who accepted on behalf of Doctor Willard the Distinguished Service Award, and Bush A. Hunter, M.D., Lexington, who received the Outstanding General Practitioner Award.

Medicare, Medicaid And Dues Increase Are Considered As KMA House Acts On 48 Reports, 14 Resolutions

The members of the Kentucky Medical Association House of Delegates were kept quite busy during the KMA Annual Meeting, September 22-24, reviewing and taking action on nearly 50 committee reports and some 14 resolutions which were submitted to them for their consideration and deliberation.

The Kentucky Medical Assistance Program was the subject creating the longest discussion on the floor of the House of Delegates. Three county societies had introduced resolutions on the KMAP Program, and the House adopted a reference committee report containing a substitute resolution following a presentation by the new Commissioner of the Department of Health, William P. McElwain, M.D.

Resolutions were approved calling for changes in various activities in which the Kentucky Medical Association is engaged. Some of those receiving positive action by the House were on the subjects of family planning, peer review, amphetamines and departments of general practice in medical schools. Another related to concern over the Medicare program; and a resolution to change requirements for foreign graduate licensure was referred back to the sponsoring county society for clarification.

The House of Delegates, without a dissent, voted to increase membership dues from the present $80 per year to $130 per year, effective January 1, 1971. However, in passing this motion, the House also voted to leave the present dues level of $80 per year for any member entering practice for the first time during his first three years of membership in the Association.

In the field of legislation and governmental medical programs, the increased activity of KMA in the 1970 Legislature was reported with emphasis on the 138 medical and/or health oriented bills introduced. The Uniform Anatomical Gift Act and the Consent to Treat Venereal Disease By Minors, which were approved for introduction into the State Legislation in 1970, were passed by the Kentucky General Assembly and are now laws of the State of Kentucky.

Of the new committees appointed, the importance of two is expected to have an early positive effect on KMA members. One of the new committees will deal strictly within the area of Public Relations, which has become a very vital and important factor in the day to day activities of KMA. Another committee will limit its responsibility to socio-economic activities for the Association.

In 1969, the House of Delegates asked that a committee be appointed to update and modernize the bylaws of the Kentucky Medical Association. During the 1970 House of Delegates meeting, this committee reported the updating that had taken place since the 1969 meeting, and the report of the committee was accepted by the House of Delegates.

The House of Delegates spent a considerable amount of time discussing the Orientation Program which became a membership requirement some years ago. It was determined by unamious consent that in future years there would be no Orientation Program at the Interim Meeting. Any new physician joining KMA will have three opportunities to attend an Orientation Program over a three year period, and the program will be held during the Annual Meeting of KMA.

All of the reports and resolutions which were submitted to and acted upon by the KMA House of Delegates will appear in the December issue of *The Journal.* It is only possible at this very early date after the Annual Meeting to touch on some of the high points covered by the House of Delegates.

Annual Meeting Receives Praise From Guests And Speakers

"I greatly enjoyed seeing how your association conducts its Annual Meeting and having lunch with you at the President's Luncheon on Wednesday. I must compliment you on the efficiency with which vour meeting is conducted and I certainly felt that I learned a great deal from our visit with you."

Tom E. Nesbitt, M.D.
President
Tennessee Medical Association
Nashville, Tennessee

"My visits to the sessions of the Kentucky Medical Association Annual Meeting were pleasant and rewarding. I enjoyed several clinical sessions, the final meeting and deliberations of the House of Delegates, and particularly the President's Luncheon."

L. T. Fruin, M.D.
President-Elect
Illinois State Medical Society
Chicago, Illinois

"I enjoyed my visit enormously and was most impressed with the warmth and hospitality of the members of the society."

David Shoch, M.D.
Professor and Chairman
Department of Ophthalmology
Northwestern University
Chicago, Illinois

"I wish to thank you and Doctor Asman for an extremely pleasant visit to Louisville. You seemed a little apologetic about the accommodations, but I assure you, your personal hospitality made up for any possible deficiency that might have existed in accommodations."

George R. Collender, Jr., M.D.
Charleston, West Virginia

"I surely enjoyed my visit with you in Louisville. It was most kind of you and the Kentucky Psychiatric Association to invite me. The discussion and the panel were especially good. I enjoyed resuming some old friendships also."

Shervert H. Frazier, M.D.
Columbia-Presbyterian Medical Center
New York, N.Y.

Nominating Committee Elected By House Of Delegates

The Nominating Committee members were elected by the KMA House of Delegates at its final session September 23. This committee is entrusted with the responsibility of presenting to the House of Delegates, at its final session of the 1971 Annual Meeting, a slate of candidates for all elective offices within the structure of the Kentucky Medical Association.

The five committee members chosen were John Baird, M.D., Danville; John H. Doyle, M.D., Louisville; Kenneth M. Eblen, M.D., Henderson; Fred C. Rainey, M.D., Elizabethtown; and Carl H. Scott, M.D., Lexington. The committee will select a chairman at its first meeting during the Interim Meeting, April 15 and 16, at Cave City.

Drug Abuse Information Available By Phone

A twenty-four hour telephone service to answer requests for information about drug abuse was recently announced by the National Clearinghouse for Drug Abuse Information.

The newly created Clearinghouse is a branch of the National Institute of Mental Health, Department of Health, Education and Welfare. It serves as the Federal focal point for drug abuse information.

The telephone number to call, around the clock, for drug abuse information is 301-496-7171.

The Clearinghouse offers a selection of publications, provides referral services, and the storage and retrieval of computerized data on drug programs.

Radiologists Elect Officers

James A. Baumgarten, M.D., Owensboro, was elected president of the Kentucky Chapter, American College of Radiology, September 22. He will take office January 1, 1971.

Ralph C. Quillin, M.D., Lexington, was chosen president-elect; Joan R. Hale, M.D., Louisville, was elected secretary; Robert D. Shepard, M.D., Lexington, councilor and Fred D. Barlow, M.D., Louisville, alternate councilor.

COMPARATIVE REGISTRATION FIGURES

KMA Annual Meetings

	Louisville 1961	Louisville 1962	Lexington 1963	Louisville 1964	Louisville 1965	Louisville 1966	Louisville 1967	Louisville 1968	Louisville 1969	Louisville 1970
KMA Members	996	1014	865	924	1172	1016	957	1009	1056	1013
Guest Physicians	194	208	141	157	138	195	152	153	149	130
Interns-Residents	102	102	69	108	132	121	94	103	95	101
Medical Students	237	176	59	128	193	209	222	185	218	245
Registered Nurses	31	59	31	34	27	33	24	42	27	48
Exhibitors	204	232	212	297	297	312	272	256	305	280
Guests	132	123	132	125	172	126	115	324	339	379
Technicians— Office Assistants	57	71	22	61	55	46	31	29	39	32
TOTAL ATTENDANCE	1953	1985	1531	1844	2186	2058	1867	2111	2228	2228

77 Physicians Attend Eleventh KMA Orientation Program

Seventy-seven physicians attended the Eleventh Orientation Program for new KMA members on September 21, according to C. Wyatt Norvell, M.D., New Castle, and Carl Cooper, M.D., Bedford, co-chairmen of the Committee on Orientation.

The Orientation Program, held during the Annual Meeting, is designed to better equip new KMA members in meeting present-day responsibilities as a citizen and as a physician.

Listed below are the names of the physicians who attended the September 21 session. If you were present and your name is not listed please notify the KMA Headquarters Office.

Harry E. Altman, M.D., Pikesville
William J. Ashbrook, M.D., Louisville
Robert A. Beargie, M.D., Lexington
Henry R. Bell, Jr., M.D., Elkton
Richard L. Bolton, M.D., Madisonville
David J. Brecount, M.D., Lexington
Raul S. Buelvas, M.D., Bowling Green
Daniel G. Camacho, M.D., Louisville
William J. Carey, M.D., Lexington
William M. Carney, M.D., Louisville
Sam E. Cecil, M.D., Campton
Samuel H. Cheng, M.D., Louisville
Gerald Clark, M.D., Madisonville
William J. Collis, M.D., Lexington
Joanne D. Corum, M.D., Louisville
Bennett L. Crowder, M.D., Hopkinsville
John A. Darpel, Jr., M.D., Erlanger
Jorge Deju, M.D., Frankfort
Frederick E. DePriest, M.D., Harlan
Nuhad D. Dinno, M.D., Louisville
Victor J. DiOrio, Jr., M.D., Louisville
George Logan Foster, M.D., Lexington
Gary Fox, M.D., Louisville
Julieta Francisco, M.D., Covington
Manuel S. Garcia, M.D., Flatwoods
Martin Gebrow, M.D., Lexington
Darius Ghazi, M.D., Louisville
Raymond C. Haley, Jr., M.D., Pikeville
Walter D. Harris, M.D., Lexington
Ted C. Hatfield, M.D., Louisville
Juan B. Hernandez, M.D., Louisville
Edward C. Hightower, M.D., Lexington
John W. Hollis, M.D., Ashland
Paul M. Hulett, M.D., Louisville
Edward N. Humston, M.D., Harrodsburg
Oliver C. James, M.D., Winchester
Donald B. Katz, M.D., Louisville
Leo L. Leveridge, M.D., Harlan
J. Myron Lord, M.D., Frankfort
Daniel C. MacDougall, M.D., Lexington
Victor P. Matibag, M.D., Louisville
William T. Maxson, II, M.D., Lexington
John K. McBain, M.D., Louisville
Roy W. Montgomery, M.D., Henderson
Kelly G. Moss, M.D., Maysville
Ramon H. Neufeld, M.D., Hyden
Felix A. Pages, M.D., Danville
Robert W. Penman, M.D., Lexington
Jerry A. Phelps, M.D., Louisville
John E. Plumlee, M.D., Lexington
Philip E. Podruch, M.D., Louisville
Louis R. Putnam, M.D., Covington
Glynn E. Reynolds, M.D., Richmond
Russell R. Rice, M.D., Louisville
Josephine W. Richardson, M.D., Louisville
Arthur L. Robertshaw, M.D., Paducah
Charles R. Rogers, M.D., Ashland
Alvaro Rojas, M.D., Augusta
Kenneth R. Rosenberg, M.D., Louisville
James M. Rouse, M.D., Louisa
James F. Rozelle, M.D., Bowling Green
Mauricio Salazar, M.D., Louisville
Arnold J. Schecter, M.D., West Point
William M. Schreiber, M.D., Louisville
Frank D. Scutchfield, M.D., Morehead
Jerry W. Seligman, M.D., Louisville
Frederick W. Sherrin, M.D., Ft. Thomas
Athel B. Sparrow, M.D., Louisville
Thomas E. Stevens, M.D., Ashland
Roy Suyemoto, M.D., Ft. Thomas
Thomas R. Taylor, M.D., Elizabethtown
Leroy E. Thompson, M.D., Louisville
David E. Townes, M.D., Louisville
Kenneth F. VonRoenn, M.D., Louisville
Paul E. Walker, M.D., S. Williamson
Paul Glenn Young, M.D., Lexington
Kenneth N. Zegart, M.D., Louisville

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(2) Samuel N. Workman, M.D.
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(3) Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry
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KMA Again Has Record Membership For 1970

Membership figures are up over last year, according to the records of the membership department. As of October 15, the total number of active Kentucky physicians who are members of KMA is 2400, which is 25 more than this time last year.

One hundred per cent KMA membership has also risen during the year. Sixty-eight counties have 100% KMA membership and 39 counties have 100% AMA membership, as compared to 66 and 39 counties respectively for 1969.

The chart below contains membership figures for each county as supplied by the membership department. Figures do not include associate and emeritus members or members who have paid 1970 dues, but have since died or left the state.

Number of Active Physicians in Kentucky Counties Who Are Members of KMA and AMA

October 15, 1970

COUNTIES	Active Physicians	MEMBERS KMA	AMA
Adair	7	6	6
Allen	5	4	4
Anderson	4	2	1
Ballard	3	2	2
Barren (*)	22	22	21
Bath	3	2	1
Bell	28	25	24
Boone	18	16	15
Bourbon	12	11	4
Boyd (*) (**)	54	54	54
Boyle	26	19	12
Bracken (*)	3	3	2
Breathitt (*) (**)	3	3	3
Breckinridge (*) (**)	5	5	5
Bullitt (*) (**)	5	5	5
Butler (*) (**)	1	1	1
Caldwell (*) (**)	6	6	6
Calloway	18	17	17
Campbell-Kenton	160	155	118
Carlisle (*) (**)	2	2	2
Carroll (*)	5	5	4
Carter	2	1	1
Casey (*) (**)	5	5	5
Christian	41	36	36
Clark (*)	13	13	11
Clay (*) (**)	5	5	5
Clinton (*) (**)	2	2	2
Crittenden (*) (**)	1	1	1
Cumberland (*) (**)	2	2	2
Daviess	67	63	55
Edmonson	2	1	1
Elliott	2	1	1
Estill (*) (**)	3	3	3
Fayette	377	330	285
Fleming (*)	3	3	0
Floyd	19	11	10
Franklin	38	37	29
Fulton (*) (**)	8	8	8
Gallatin (*) (**)	1	1	1
Garrard	3	2	2
Grant (*) (**)	4	4	4
Graves (*) (**)	16	16	16
Grayson	6	5	5
Green (*)	7	7	5
Greenup (*) (**)	10	10	10
Hancock	3	2	1
Hardin (*)	29	29	20
Harlan	43	35	34
Harrison (*)	9	9	5
Hart	6	5	5
Henderson	32	31	30
Henry (*) (**)	3	3	3
Hickman (*)	2	2	1
Hopkins	50	48	48
Jackson (*) (**)	1	1	1
Jefferson	826	796	633
Jessamine (*)	3	3	2
Johnson (*) (**)	8	8	8
Kenton—See Campbell			
Knott (*) (**)	2	2	2
Knox	9	8	3
Larue (*)	3	3	1
Laurel	9	8	8
Lawrence (*) (**)	10	10	10
Lee (*) (**)	1	1	1
Leslie (*)	4	4	3
Letcher	11	8	8
Lewis	2	0	0
Lincoln (*) (**)	3	3	3
Livingston	4	1	0
Logan	11	10	9
Lyon (*)	3	3	2
McCracken	72	67	63
McCreary	3	2	2
McLean (*)	4	4	0
Madison (*)	25	25	20
Magoffin (*) (**)	3	3	3
Marion (*) (**)	8	8	8
Marshall (*)	10	10	9
Martin (*) (**)	3	3	3
Mason	13	12	10
Meade (*)	3	3	1
Menifee	0	0	0
Mercer	11	10	8
Metcalfe (*)	2	2	1
Monroe	7	6	6
Montgomery	10	8	6
Morgan (*)	3	3	2
Muhlenberg (*)	11	11	9
Nelson (*) (**)	8	8	8
Nicholas (*)	3	3	0
Ohio	8	7	1
Oldham (*)	8	8	7
Owen (*) (**)	2	2	2
Owsley (*) (**)	2	2	2
Pendleton (*)	3	3	2
Perry (*)	17	17	14
Pike	42	31	29
Powell (*) (**)	1	1	1
Pulaski (*)	29	29	27
Robertson	0	0	0
Rockcastle	2	1	1
Rowan	11	10	9
Russell (*) (**)	3	3	3
Scott (*)	8	8	2
Shelby (*)	9	9	7
Simpson (*)	6	6	4
Spencer (*) (**)	2	2	2
Taylor (*)	6	6	5
Todd (*) (**)	3	3	3
Trigg (*) (**)	6	6	6
Trimble (*) (**)	2	2	2
Union	4	3	3
Warren	53	49	38
Washington (*) (**)	4	4	4
Wayne (*)	6	6	5
Webster	3	2	2
Whitley	20	18	17
Wolfe (*) (**)	2	2	2
Woodford	8	7	2
Totals	2583	2400	2007

(*) 100% KMA

(**) 100% AMA

AAGP Changes Name

The American Academy of General Practice, national association of family physicians and the nation's second largest medical group, recently announced a change in its name. It will become known as the American Academy of Family Physicians.

The action, which will take a year to develop fully, was taken by the Academy's Congress of Delegates in the final session of the group's annual meeting held recently in San Francisco. At this same meeting J. Jerome Wildgen, M.D., Kalispell, Montana, was chosen president-elect; William E. Lotterhos, M.D., Jackson, Miss., became president.

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1970 House of Delegates

KMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	Richard F. Greathouse	Present	Present
Vice-Speaker	Carl Cooper, Jr.	Present	Present
President	Walter L. Cawood	Present	Present
President-Elect	John C. Quertermous	Present	Present
Vice-President	David A. Hull	Present	Present
Secretary	S. Randolph Scheen	Present	Present
Treasurer	Keith P. Smith	Present	Present
Delegate to AMA	J. Thomas Giannini	Present	Present
Delegate to AMA	Charles C. Rutledge	Present	Present
Delegate to AMA	George Brockman	Present	Present
Alternate Delegate to the AMA	Charles G. Bryant	Present	Present
Alternate Delegate to the AMA	Daryl P. Harvey	Present	Present
Alternate Delegate to the AMA	David B. Stevens	Present	Present

TRUSTEES

District			
First	C. C. Lowry	Present	Present
Second	William W. Hall	Present	Present
Third	Thornton E. Bryan, Jr.	Present	Present
Fourth	W. Bruce Hamilton	Present	Present
Fifth	John S. Llewellyn	Present	Present
Sixth	Paul J. Parks	Present	Present
Seventh	Donald Chatham	Present	Present
Eighth	Lee C. Hess	Present	Present
Ninth	J. Campbell Cantrill	Present	Present
Tenth	Andrew M. Moore	Present	Present
Eleventh	Douglas H. Jenkins	Present	Present
Twelfth	Robert N. McLeod, Jr.	Present	Present
Thirteenth	Paul E. Holbrook	Present	Present
Fourteenth	Ballard W. Cassady	Present	Present
Fifteenth	E. C. Seeley	Present	Present

PAST PRESIDENTS

Past President	Henry B. Asman	Present	Present
Past President	George Brockman	Present	Present
Past President	Robert E. Pennington	Present	Present
Past President	Delmas Clardy	Present	Present
Past President	George Archer	Present	Present

DELEGATES

First District

		First Session	Second Session
BALLARD			
CALLOWAY	Hugh Houston	Present	Present
CARLISLE	J. T. O'Neill	.....	.....
FULTON	R. W. Bushart	.....	.....
GRAVES	C. Douglas LeNeave	Present	Present
HICKMAN	C. J. Mills	.....	.....
LIVINGSTON			
McCRACKEN	Donald Boucher	.....	.....
	W. Burton Haley	Present	Present
	Walter Johnson	Present	Present
MARSHALL	Keith E. Ellis	Present	Present

Second District

DAVIESS	Coy Ball	Present	Present
	J. S. Oldham	Present	Present
	William E. Pearson	Present	Present
HANCOCK	B. P. Smith	.....	.....
HENDERSON	Kenneth Eblen	Present	Present
	Charles Kissinger	Present	Present
McLEAN	Everett S. Coleman	.....	.....
OHIO	R. E. Norsworthy	Present	.....
	Charles L. Price (Alt.)	.....	Present
UNION	Wallas N. Bell	Present	Present
WEBSTER	Paul M. Taylor	Present	.....

Third District

CRITTENDEN	R. M. Brandon	.....	.....
HOPKINS	C. R. Fisher	Present	Present
	F. S. Trover	Present	Present
LYON	Max C. Salb	.....	.....
PENNYRILE MEDICAL SOCIETY			
CALDWELL	Billy G. Jackson	Present	.....
CHRISTIAN	James B. Cox	Present	Present
	W. Faxon Payne	.....	.....
MUHLENBERG	Joseph K. Stokes	Present	.....
TODD	Ralph D. Lynn	.....	Present
TRIGG	William N. Richardson	Present	Present

Fourth District

BRECKENRIDGE	James G. Sills	.....	.....
	R. G. Chambliss (Alt.)	.....	Present
BULLITT	Patrick Murphy	Present	Present
GRAYSON	Charles L. Eland	.....	.....
GREEN	Harry B. Huntsman	Present	Present
HARDIN	Fred C. Rainey	Present	Present
	Robert E. Robbins	Present	Present
HART	George Boeckmann, Jr.	Present	Present
LARUE	Marion A. Douglass, Jr.	Present	Present
MARION			
MEADE			
NELSON	Kenneth L. Stinnette	Present	Present
TAYLOR	Roy G. Wilson	Present	.....
	M. M. Hall (Alt.)	.....	Present
WASHINGTON	Dixie Snider	Present	.....

Fifth District

JEFFERSON	John D. Allen, Jr.	Present	Present
	James G. Baker	Present	Present
	William H. Bizot	Present	Present
	Thomas E. Booth	Present	.....
	Glenn W. Bryant	Present	Present
	Peter C. Campbell, Jr.	Present	Present
	W. Neville Caudill	Present	Present
	Elbert G. Christian	Present	Present
	Morgan R. Colbert	Present	Present
	Eugene Conner (Alt.)	.....	Present
	Fred E. Coy, Jr.	Present	Present
	James Davis (Alt.)	.....	Present
	John H. Doyle	Present	Present
	Frank M. Gaines, Jr.	Present	Present
	John N. Goldsborough	.....	Present
	R. F. Greathouse	Present	Present
	Cecil L. Grumbles	Present	Present
	Harold D. Haller, Sr.	Present	Present
	N. I. Handelman	.....	Present
	Charles M. Hargadon	Present	Present
	Lonnie Howerton	.....	.....
	Michael G. Kemper	Present	Present
	Edward N. Maxwell	Present	Present
	Robert L. McClendon	Present	Present
	Clyde T. Moore	Present	.....
	Herman R. Moore, Jr.	Present	Present
	Charles Oberst	.....	.....
	A. E. Overstreet (Alt.)	Present	Present
	Bernard I. Popham	.....	Present
	Carroll H. Robie, Jr.	.....	Present
	W. Fielding Rubel	Present	Present
	Everett Sanneman	Present	Present
	G. Randolph Schrodt	Present	Present
	Mark S. Sexter	.....	.....
	Charles C. Smith, Jr.	.....	Present
	Edwin P. Solomon, Jr.	.....	Present

Sixth District

ADAIR	J. C. Salato	Present	Present
ALLEN	Earl P. Oliver	Present	Present
BARREN	William H. Bryant	Present	.....
BUTLER			
CUMBERLAND	James W. Morris	.....	.....
EDMONSON			
LOGAN	C. V. Dodson	Present	.....
METCALFE	L. P. Emberton	.....	.....
MONROE	James E. Carter	.....	.....
SIMPSON	Douglas R. Alvey	.....	Present
WARREN	Harold Keen (Alt.)	Present	.....
	Paul J. Parks	Present	Present
	J. O. Willoughby	Present	Present

The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 21 and 23.

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Specific therapy for night leg cramps

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Was Your Delegate Present?

Seventh District

ANDERSON	Boyd Caudill	.....	.....
CARROLL	Edgar S. Weaver	.....	.....
FRANKLIN	B. B. Baughman	Present	Present
	Sandford L. Weiler	Present	Present
GALLATIN	John D. Fielding	Present	.....
GRANT			
HENRY			
OLDHAM			
OWEN	Maurice Bowling	.....	.....
SHELBY	Ronald Waldridge	Present	Present
SPENCER	William K. Skaggs	.....	.....
TRIMBLE	Carl Cooper, Jr.	Present	Present

Eighth District

BOONE	Glenn F. Baird	.....	Present
CAMPBELL-KENTON	Carl J. Brueggemann	Present	Present
	T. L. Heavern, Jr.	Present	Present
	Donald Janney	.....	.....
	P. H. Klingenberg (Alt.)	.....	Present
	Louis J. Nutini	.....	.....
	W. Vinson Pierce	Present	Present
	R. C. Smith	Present	Present
	Raymond J. Timmerman	Present	.....

Ninth District

BATH	Robin A. Byron	.....	.....
BOURBON	Richard Wever	.....	Present
BRACKEN	J. M. Stevenson	Present	Present
FLEMING	R. W. Fidler (Alt.)	Present	Present
HARRISON	Don R. Stephens	Present	Present
MASON	M. B. Denham	Present	.....
	W. M. Savage (Alt.)	.....	Present
NICHOLAS	W. R. Kingsolver	.....	.....
PENDLETON	Robert L. McKenney	.....	.....
ROBERTSON			
SCOTT	R. Kendall Brown	Present	Present

Tenth District

FAYETTE	John F. Berry, Jr.	Present	Present
	Leslie W. Blakey	Present	Present
	Peter P. Bosomworth	Present	Present
	N. L. Bosworth	Present	Present
	Thomson R. Bryant, Jr.	Present	Present
	Winston L. Burke	Present	Present
	Donald E. Edger	Present	Present
	Richard D. Floyd	Present	.....
	Richard F. Hench	Present	Present
	David A. Hull	Present	Present
	Bush A. Hunter	Present	Present
	Richard B. McElvein	Present	Present
	Porter Mayo (Alt.)	.....	Present
	Carl H. Scott	Present	.....
	Ben C. Stigall	Present	Present
JESSAMINE	J. Sankey Williams	.....	Present
WOODFORD	George C. Reed	Present	.....

Eleventh District

CLARK			
ESTILL	Charles E. Terry	.....	.....
JACKSON	D. L. Peterson	.....	.....
LEE			
MADISON	Dwight L. Blackburn	.....	.....
	Glynn Reynolds	Present	Present
MENIFEE			
MONTGOMERY	R. J. Salisbury	Present	Present
OWSLEY	Arnold Taulbee	.....	.....
POWELL	Charles Noss	.....	.....
WOLFE	Sam E. Cecil	.....	.....

Twelfth District

BOYLE	John M. Baird	Present	Present
CASEY	Lewis E. Wesley	.....	.....
CLINTON	Earnest A. Barnes	.....	.....
GARRARD	Paul J. Sides	Present	Present
LINCOLN	Edward C. Bowling	.....	.....
McCREARY	H. A. Perry	.....	.....
MERCER	John S. Baughman, III	.....	.....
PULASKI	John P. Hill, Jr.	Present	.....
	Stephen B. Kelley	Present	Present
ROCKCASTLE	George H. Griffith	.....	.....
RUSSELL	James E. Monin	.....	.....
WAYNE	Claude L. McHargue	.....	.....

Thirteenth District

BOYD	G. C. Cunningham (Alt.)	Present	Present
	C. Gordon Gussler	Present	.....
	G. E. Robinson	.....	.....
	Clyde C. Sparks	Present	Present
CARTER	H. E. Shufflebarger	.....	.....
ELLIOTT	John F. Greene	.....	.....
GREENUP	John O. Jones	.....	.....
LAWRENCE	A. B. Richards	Present	Present
LEWIS			
MORGAN	Morris Peyton	.....	.....
ROWAN	Donald Blair	.....	Present

Fourteenth District

BREATHITT	F. C. Lewis	.....	.....
FLOYD	George Archer	Present	Present
JOHNSON	Jerry D. Fraim	Present	Present
KNOTT	D. G. Barker	.....	.....
LETCHER	James B. Tolliver	.....	.....
MAGOFFIN			
MARTIN	Raymond D. Wells	Present	.....
PERRY	Donald Martin	.....	Present
PIKE	H. E. Altman	Present	.....
	Paul Odom	Present	Present

Fifteenth District

BELL	Kenneth W. Smith	.....	.....
	Charles B. Stacy	Present	.....
CLAY	W. E. Becknell	Present	Present
HARLAN	Howard L. Elliott	Present	Present
	W. H. Stepchuck (Alt.)	Present	Present
KNOX	Harold L. Bushey	Present	Present
LAUREL	John B. Rypstra	Present	Present
LESLIE	W. B. R. Beasley	.....	Present
WHITLEY	Roemer D. Pitman	Present	Present

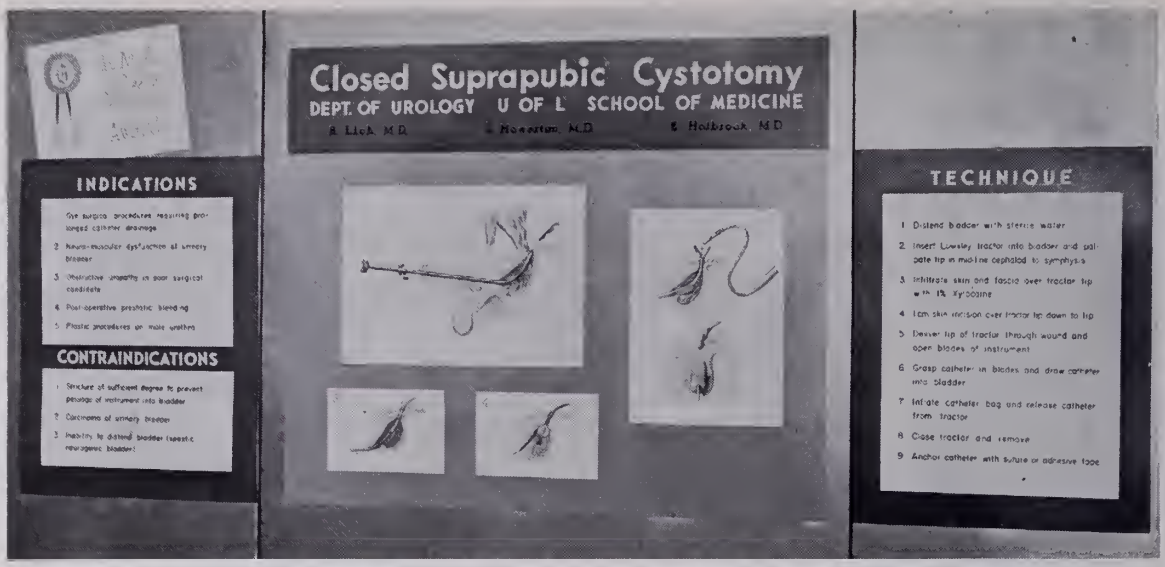
F.A.C.S. Degree Awarded To 15 Kentucky Surgeons

Fifteen Kentucky physicians were inducted as Fellows of the American College of Surgeons at the organization's 56th Annual Clinical Congress in Chicago, October 12-16.

Fellowship, a degree entitling the recipient to the designation F.A.C.S. following the doctor's name, is awarded to those surgeons who fulfill comprehensive requirements of acceptable medical education and advanced training as specialist in one or more branches of surgery, and who give evidence of good moral character and ethical practice.

The Kentuckians who received this distinction at the 1970 convocation are: Robert M. Runge, M.D., Covington; Thomas D. Pruitt, Jr., M.D., Harlan; George S. Beard, M.D., Hartford; Preston V. Dilts, Jr., M.D., Charles R. Sachatello, M.D., William R. Jewell, M.D., John M. Stoeckinger, M.D., Jonathan D. Wirtschafter, M.D., all of Lexington; Erdogan Atasoy, M.D. and Bobby M. Deweese, M.D., of Louisville; Jack L. Hamman, M.D., Madisonville; Henry B. Keister, M.D , Mayfield; and Hal E. Houston, M.D., Murray; Wally O. Montgomery, M.D., and Frank E. Reeder, M.D., of Paducah.

The American College of Surgeons is a voluntary scientific and educational association of surgeons, numbering 31,000 in 92 countries. The College was founded in 1913 to improve care of the surgical patient, and has pioneered in many directions in making surgical care as excellent as it is today.



The scientific exhibit pictured above, "Closed Suprapubic Cystotomy" by Robert Lich, Jr., M.D., Lonnie W. Howerton, Jr., M.D., and Ernest C. Holbrook, M.D., all of the department of urology at the University of Louisville School of Medicine, was given the KMA Gold Medal Award at the Annual Meeting. The Silver Medal Award went to Paul M. Weeks, M.D., and William Jewell, M.D., both of Lexington, for the exhibit "Combined Ablative-Restorative Surgery for Head and Neck Cancer." Thomas A. Kelley, Jr., M.D., Louisville, was awarded the Bronze Medal for "Restoration of the Physically Disabled."

Author Addresses Luncheon

Ralph Lee Smith addressed over 300 KMA members and their guests at the President's Luncheon, October 23.

Mr. Smith, author of the book *At Your Own Risk*, discussed a chapter from his well-known expose of chiropractic.

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Julieta B. Francisco, M.D., is now practicing in Covington, Ky. A native of the Philippines, Doctor Francisco has a specialty in Internal Medicine. He completed his residency at the St. Joseph Hospital in Milwaukee.

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1. Date of filing: October 1, 1970.
2. Title of publication :THE JOURNAL OF THE KENTUCKY MEDICAL ASSOCIATION.
3. Frequency of issue: monthly.
4. Location of known office of publication: 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.
5. Location of the headquarters or general business office of the publishers: 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.
6. Names and addresses of publishers, editor, and managing editor: Publisher—Kentucky Medical Association, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205. Editor—Walter I. Hume, Jr., M.D., 768 Medical Towers South, Louisville, Ky. 40202. Managing Editor—Robert G. Cox, 3532 Ephraim McDowell Drive, Louisville, Ky. 40205.
7. Owner: Kentucky Medical Association.
8. Known bondholders, mortgagees, and other security holders owning or holding one per cent or more of total amount of bonds, mortgages or other securities: none.
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	Average No. Copies each issue during preceding 12 months	Single issue nearest filing date
A. Total no. copies printed:	3215	3250
B. Paid circulation		
1. Sales through dealers and carriers, street vendors and counter sales:	129	131
2. Mail subscriptions:	2696	2710
C. Total paid circulation:	2825	2841
D. Free distribution, including samples by mail, carrier, or other means:	340	362
E. Total distribution:	3165	3203
F. Office use, left-over, unaccounted, spoiled after printing:	50	47
G. Total:	3215	3250

I certify that the statements made by me above are correct and complete.

Robert G. Cox, Managing Editor

Ky. Group Installs President

Albert G. Goldin, M.D., Louisville, was installed as president of the Kentucky Chapter of the American College of Chest Physicians, during a meeting of the group held during the KMA Annual Meeting.

Paul M. Walstad, M.D., Harlan, was chosen president-elect; Paul A. Pichardo, M.D., Glasgow, is secretary-treasurer. Governor of the group is Michael Furcolow, M.D., Lexington.

Tournament Winners Announced

The winners of the 1970 Annual Doctors Golf Tournament, held in September, were recently announced by Donald L. Ware, M.D., Louisville, secretary of the Golf Association.

The winners are: Low Gross—first place, Arthur T. Daus, Jr., M.D.; second, Gordon L. Hyde, M.D.; third, Chester M. Blanton, M.D.; fourth, Harold B. Graves, M.D., and Mervel V. Hanes, M.D.; Low Net—first, John M. Karibo, M.D.; second, Bob M. DeWeese, M.D.; third, Walter L. Wilson, M.D., and Oscar W. Thompson Jr., M.D.

Special Handicap winners are: first, Ronald L. Levine, M.D.; second, John E. Ryan, M.D.; third, C. William Dowden, M.D., and Donald L. Ware, M.D. The Sportsman Award went to Bernard O. Rand, M.D., and A. Evan Overstreet, M.D. The Special Sportsman Award went to John B. Southard, M.D. The Best Dressed Golfer prize was awarded to Donald L. Ware, M.D.; second, John E. Meyers, Jr., M.D.; third, K. Vincent Ziegler, M.D.

Winners may pick up their prizes at Hurstbourne Country Club Golf Shop or may receive them through the mail by contacting Donald L. Ware, M.D., at 583-8341.

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Treatment of Diabetic Retinopathy
(Continued from Page 730)

presented at the Public Health Symposium on diabetic retinopathy treated by photocoagulation, supported the clinical impression that this mode of treatment has been an effective determinant to visual loss in suitably selected cases.[8] In order to arrive at a statistically significant conclusion, the analysis made apparent the need for numerous long-term controlled and accurately classified series.

References

1. Davis, M.D., Meyers, F. L., Engerman, R. L., DeVenecia, G., and Magli, Y. L.: *Symposium—Treatment of Diabetic Retinopathy,* Washington, D.C., United States Government Printing Office, pp. 47, 1969.
2. Spalter, H. F.: *Symposium—Treatment of Diabetic Retinopathy,* Washington, D.C., United States Printing Office, pp. 545, 1969.
3. Lincoff, H. A.: Guilty Until Proven Innocent, *Archives of Ophthalmology,* 78:271, 1967.
4. Patz, A. and Berkow, J.W.: Visual and Systemic Prognosis in Diabetic Retinopathy, *Transactions of the Academy of Ophthalmology and Otolaryngology,* 72:253, 1968.
5. Wetzig, P. and Jepson, N.: Treatment of Diabetic Retinopathy by Light Coagulation, *American Journal of Ophthalmology,* 62:459, 1966.
6. McMeel, J.W. and Van Heuven, W.A.J.: *Symposium—Treatment of Diabetic Retinopathy,* Washington, D.C., United States Government Printing Office, pp. 507, 1969.
7. Okun, E.: The Effectiveness of Photocoagulation in the Therapy of Proliferative Diabetic Retinopathy, *Transactions of the Academy of Ophthalmology and Otolaryngology,* 72:246, 1968.
8. Davis, M.D., and Myers, F.L.: *Symposium—Treatment of Diabetic Retinopathy,* Washington, D.C., United States Government Printing Office, pp. 701, 1969.

Neuroblastoma, Presenting Signs
(Continued from Page 732)

In many children presenting with unexplained chronic complaints, neuroblastoma should at least be considered as a possible cause and appropriate simple tests applied. This may initiate rapid therapy, or prevent unnecessary surgical procedures in proper programming for palliation.

Acknowledgement

Our appreciation to Mrs. Hazel Puckett, secretary of the Oncology Board, who aided considerably in compiling this information.

References

1. Neuroblastoma Sympatheticum. A Study and Report of 217 Cases. Gross, R. E., Farber, S., Martin, L. W., *Pediatrics,* 23: 1179-1191, 1959.
2. Neuroblastoma: Management and Survival. Lingley, J. F., Sagerman, R. H., Santulli, T. V., Wolff, J. A., *New Eng. J. Med.,* 277: 1227-1230, 1967.
3. Treatment of Malignant Sympathetic Tumors in Children: Clinicopathological Correlation. Perez, C. A., Vietti, T. J., Ackerman, L. V., Kulapongs, P., Powers, W. E., *Pediatrics,* 41: 452-462, 1968.
4. Neuroblastoma in Children. de Lorimier, A. A., Bragg, K. U., Linden, G., *Amer. J. Dis. Child.,* 118: 441-450, 1969.
5. Recent Results in Cancer Research. *Neuroblastomas-Biochemical Studies.* Editor, C. Bohuon, Springer-Verlag, Heidelberg, New York, 1966.

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THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



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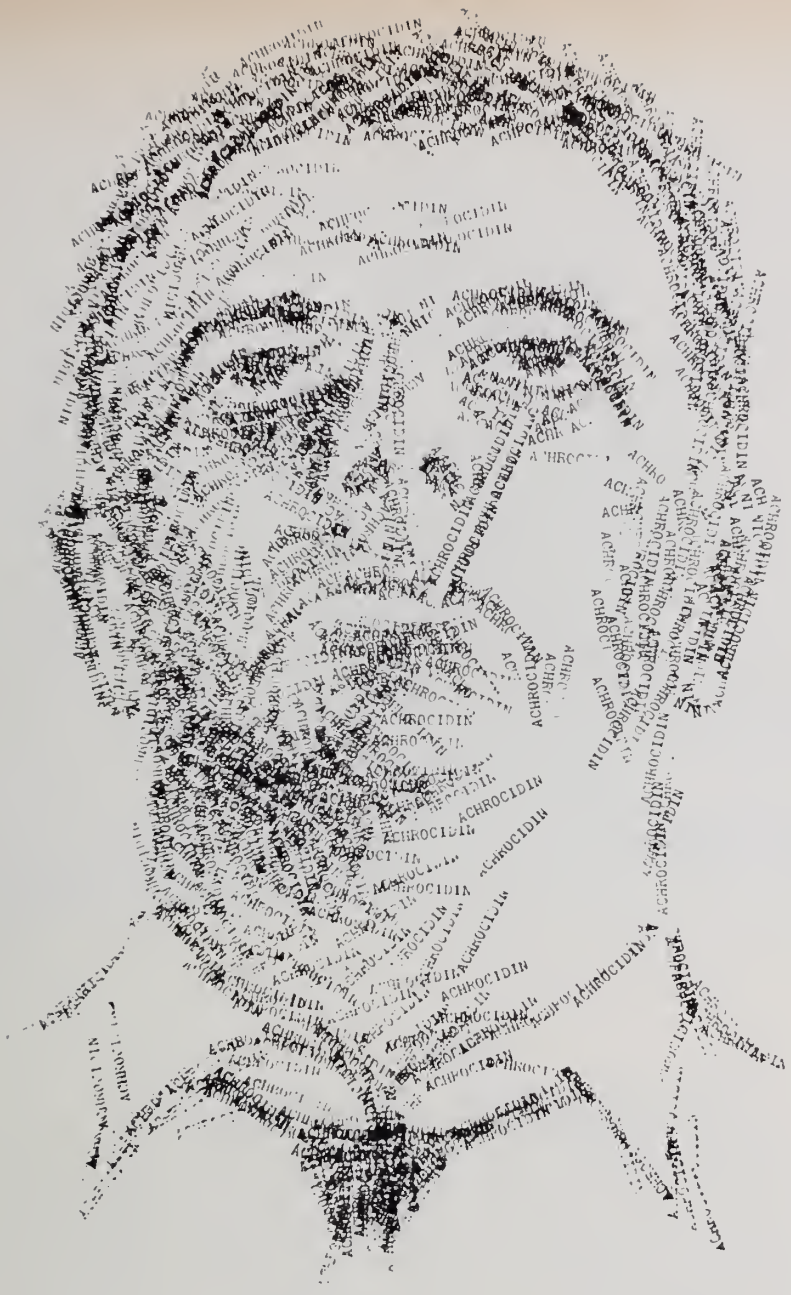
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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported an recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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VOLUME 68 DECEMBER 1970 NUMBER 12

The Journal of The KENTUCKY Medical Association

Season's Greetings



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References:
(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.

PUBLISHED TO REPLACE A PREVIOUS ADVERTISEMENT WHICH THE FOOD AND DRUG ADMINISTRATION CONSIDERED MISLEADING

The Food and Drug Administration has requested that we bring to your attention a recent promotional campaign for Garamycin Injectable (gentamicin sulfate) which featured a nationwide *in-vitro* hospital survey involving a comparison of sensitivity patterns of Garamycin Injectable and seven other antibiotics.

The FDA considers the advertising misleading in several respects such as:

The *in-vitro* chart contained in the ads, which compared Garamycin Injectable with seven other antibiotics, implied that Garamycin Injectable is clinically more effective than the seven other compared antibiotics. THE FACTS ARE (1) THAT DIRECT EXTRAPOLATION OF NONCLINICAL FINDINGS TO CLINICAL EFFECTIVENESS IS UNWARRANTED, AND (2) THAT THE ADVERTISED *IN-VITRO* COMPARISONS DO NOT CONSTITUTE A VALID BASIS FOR SUGGESTING THAT GARAMYCIN INJECTABLE HAS GREATER CLINICAL EFFECTIVENESS THAN THE COMPARED ANTIBIOTICS.

The *in-vitro* chart and information contained under the ad heading, "Indications" presented *in-vitro* data results in such a way as to imply that the drug is indicated for Gram-positive bacteria, such as *Staphylococcus aureus.* GARAMYCIN INJECTABLE IS NOT APPROVED FOR INFECTIONS DUE TO ANY GRAM-POSITIVE ORGANISMS.

We emphasize that Garamycin Injectable is approved for use only in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter.

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BRIEF SUMMARY

INDICATIONS GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly Pseudomonas aeruginosa, Proteus and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

CONTRAINDICATIONS GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

WARNINGS Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

PRECAUTIONS In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentration of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

ADVERSE REACTIONS The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

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Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.

Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

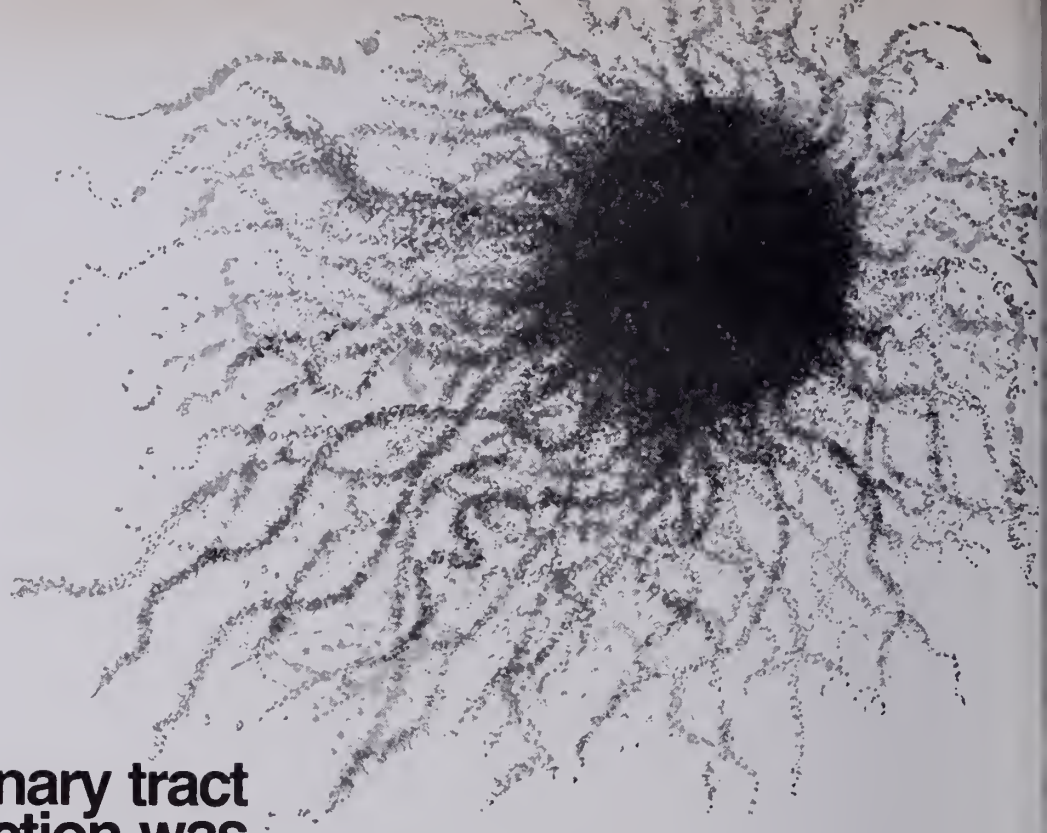
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to move,
and the Latin **sedatus,**
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Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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DECEMBER

9-10 Postgraduate course, "Current Concepts in Opthalmology," Cleveland Clinic Educational Foundation, Cleveland, Ohio

JANUARY

7-9 National Conference on Cancer of the Colon and Rectum, American Cancer Society, San Diego, Calif.

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SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their winter and spring meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can to avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Ephraim McDowell Drive, Louisville, Ky. 40205.



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Q. What is Pre-Admission Testing (PAT)?

A. *PAT is a voluntary program between Blue Cross, its Member Hospitals and their medical staffs to provide coverage for outpatient tests such as laboratory examinations, x-rays, and E. K. G.'s done at the hospital prior to a scheduled admission as an inpatient. Pre-Admission Testing is available only at a Member Hospital which, with its Medical Staff, has executed formal agreement with Blue Cross to implement the program.*

Q. Under what conditions would PAT benefits be provided?

A. *PAT is designed to shorten the inpatient stay by having results of testing available at the time of admission, so that prompt treatment can follow. PAT can also help to alleviate some of the bed shortage in hospitals where it is utilized, and may permit better scheduling within x-ray and laboratory departments.*

Q. Under what conditions would PAT benefits be provided?

A. *Three conditions are necessary for PAT benefits to apply: (1) the patient must be scheduled for admission prior to the Pre-Admission Testing; (2) the use of PAT will reduce the length of inpatient stay; and (3) the results will be relevant to the diagnosis and medically valid at the time the patient is admitted.*

Q. How does PAT work?

A. *There are four steps to be followed:*

1. *The physician schedules the inpatient admission.*
2. *The physician orders the Pre-Admission Testing in writing on a special form provided by Blue Cross.*
3. *The patient must visit the hospital for testing prior to admission.*
4. *Test results are reported to the physician and are on the chart at the time of admission.*

Q. Can PAT be used to determine if hospitalization on an inpatient basis is necessary?

A. *PAT is not intended to determine if hospital care is necessary and no payment would be made for testing done for this purpose.*

Q. Are there increased dues to the subscriber for Pre-Admission Testing and coverage?

A. *Since the tests covered by Pre-Admission Testing are the type which would have been covered on an inpatient basis, there is no dues increase associated with PAT. Overall, PAT may help to hold dues to their present level for a longer period of time.*

Q. If a hospital and its Medical Staff agree to use PAT, will the physician be bound to use only this system?

A. *PAT is a voluntary program and no physician will be required to perform Pre-Admission Testing. PAT is simply an approach designed to promote more efficient use of hospital beds.*

Q. Who is eligible for PAT coverage?

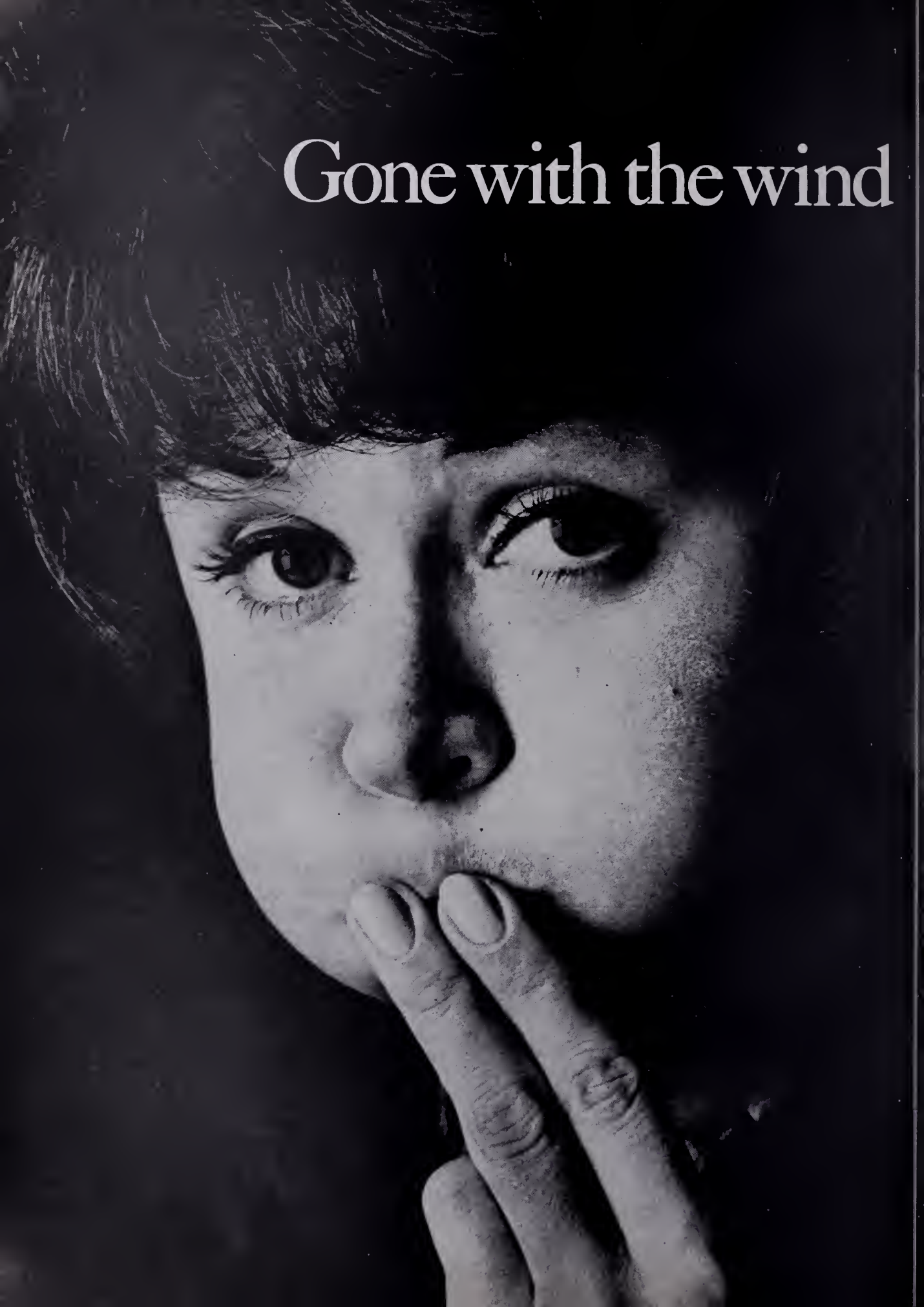
A. *All Blue Cross Members are eligible for PAT, who receive testing at a Member Hospital which, with its Medical Staff, has executed a formal agreement with Blue Cross.*

Q. What occurs if the scheduled inpatient admission is cancelled?

A. *If the scheduled inpatient admission is cancelled, Blue Cross will not cover PAT charges except where catastrophic or unavoidable situations make admission impossible. Special procedures will be in effect at each participating hospital for the attending physician to request payment in such cases.*

Q. How can a physician learn more about Pre-Admission Testing?

A. *Any physician wanting more information about PAT may contact the Professional Relations Department, Kentucky Physicians Mutual, Inc., 3101 Bardstown Road, Louisville, Kentucky 40205.*


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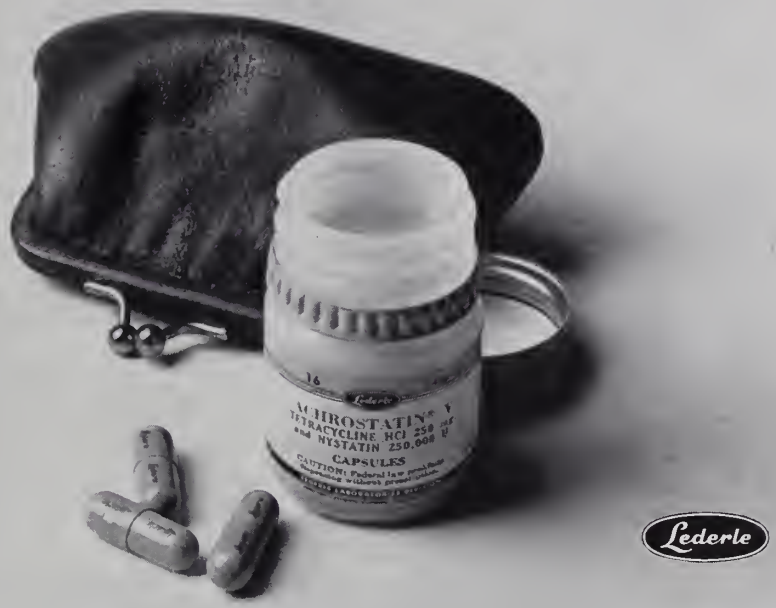
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VOLUME 68 DECEMBER, 1970 No. 12

Thyroid Disease in Children†

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Louisville, Kentucky

A high index of suspicion is vital to early detection of thyroid hypofunction. The images of cretinism and juvenile myxedema are presented.

THE SPECTRUM of thyroid disease in childhood is similar to that in adults, but its manifestations differ in one major respect; they are superimposed upon a growing, developing individual. Hypothyroidism is thus associated with arrest of linear growth and retardation of development, while hyperthyroidism is associated with a degree of linear over-growth.

Hypothyroidism comprises approximately two-thirds of all thyroid disease in childhood[1] and will be the principal topic of this discussion. Graves Disease occurs throughout childhood, particularly in the pre-adolescent and adolescent girl, but presents few problems unique to the pediatric age group, and will not be considered further.

Goiter in childhood occurs with considerable frequency and represents either a) a metabolic disturbance such as an enzymatic defect, ingestion of a goitrogen, Graves Disease, etc., or b) an inflammatory process such as Hashimoto's Disease, or c) tumor formation. Through appropriate studies an attempt should be made to determine the etiology of all childhood goiters. Merely descriptive terms such as simple goiter, colloid goiter, and adolescent goiter should be avoided.

In childhood, loss of thyroid function after the age of two or three years of life will result in the characteristic features of myxedema, plus growth retardation, but no permanent intellectual impairment.[2] In contrast, inadequate thyroid function in utero or during the most rapid periods of brain myelinization, which occur during the first two or three years of postnatal life, results in the clinical picture of cretinism, with short stature, classic body and facial configuration, and often irreparable central nervous system damage.[2]

Cretinism

In the majority of cases, cretinism is the result of a congenital agenesis or dysgenesis of the thyroid gland. Rarely it is due to an inborn enzymatic defect, iodine deficiency in the mother, or ingestion of goitrogens by the mother. In the athyrotic cretin signs and symptoms of hypothyroidism may antedate delivery. The mother may notice a paucity of fetal movements, and x-rays at the time of birth may show retardation of fetal skeletal maturation. Irreparable brain damage may also have occurred as the result of fetal thyroid deprivation. Although a small amount of transfer of thyroid hormone from mother to fetus may occur, in most instances this is not adequate to support normal maturation of the CNS and skeleton.[3]

Although many texts suggest that cretinism cannot be diagnosed early in the newborn period, the perceptive examiner with a high index of suspicion can make this diagnosis in

†*Presented at the Norton Memorial Infirmary 12th Annual Post Graduate Medical Seminar, Louisville, Kentucky, December 18, 1969*

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the newborn nursery. Among the most characteristic features of cretinism in the newborn period is nasal stuffiness. Nasal obstruction is such that the infant frequently chokes and gags during feeding and after several unsuccessful attempts at feeding will refuse the nipple and go quietly back to sleep.[4] At this time the baby will seem floppy, mottled, and have a rather hoarse cry. Physiological jaundice may be more marked and more prolonged than usual.

Later in the first month of life symptoms of lethargy, constipation, feeding difficulties, respiratory problems, dry skin, thick tongue, hoarse cry, and umbilical hernia may fail to arouse much attention, because the infant is such a "good" baby. The infant generally sleeps through the night without feeding and, although he feeds poorly, fusses very little.

The physician examining a cretin in the first six months may overlook many of the characteristic physical findings unless he has a high index of suspicion. Umbilical hernia, lethargy, and retarded growth are obvious in most cases during this period. Because the weight is less retarded than the length, the physician may underestimate the true degree of growth failure in these children, if he focuses attention only on weight. By the time the full syndrome consisting of pot belly, dry skin, large tongue myxedema, hypothermia, brady-cardia, refractory anemia, and easily recognizable retardation of growth and development develops, most physicians will diagnose cretinism; but by then it may be too late for full salvage of mental development.

Where the physician does not have a high index of suspicion, the subtle signs will frequently be mis-diagnosed as iron deficiency anemia and iron therapy instituted. The anemia of cretinism does not respond to iron but responds promptly to thyroid replacement.

The laboratory substantiation of a clinical suspicion of cretinism must be undertaken with care. As PBI values normally run from 8 - 12 ug% in the first two weeks of life, a value in the usual "normal" range for this index of thyroid function does not exclude cretinism during this period.[5] In untreated cretinism, the serum cholesterol may not be elevated during the first year and cannot be counted upon as a diagnostic tool.[1] The simplest screening test for cretinism is an x-ray of the knee joint. Failure of ossification of the upper tibial and lower femoral epiphyses is suggestive of cretinism unless the infant is premature. Where ossification of these epiphyses has not occurred in an infant suspected of having cretinism, a tracer dose of radioiodine to demonstrate the presence or absence of a functioning thyroid is indicated. A diagnosis of athyrotic cretinism may thus be quickly confirmed or ruled out by these two tests. Estimation of the serum thyroxin, T_3 uptake, and alkaline phosphotase are other suggested confirmatory tests.

The treatment of cretinism may be instituted at a definitive dose level, providing thyroxin is used and the rapid effect of trioiodothyronine, which is found in preparations of desicated thyroid, is avoided. A dose of 100 micrograms of L-thyroxin may be started immediately upon diagnosis. As it will take a little over one week for the full accummulative effect of this dose to be manifest, one need not fear precipitation of adrenal insufficiency or cardiac failure by abrupt institution of this definitive dose. This also avoids the delay in reaching a definitive level associated with the frequently used progression from a quarter grain of desicated thyroid up to one grain, which may consume many weeks or months of this vital period of development. One hundred ug to 150 ug of l-thyroxin, the equivalent of one to one and one-half grains of desicated thyroid, should be an adequate dose for the first two years, with adjustments in dosage being based on growth, maturation and the disappearance of the clinical features of myxedema and hypothyroidism. Proper treatment should result in the restoration of normal growth to these children, although some impairment of mental development frequently remains. The earlier treatment is instituted, the better for the individual patient. However, the severity of the cretinism at the time of the diagnosis adversely affects the outlook, so that a florid cretin treated at two months of age may not do as well as a cretin picked up on subtle signs and symptoms at four months of age. Although studies by some authorities suggest that close to fifty percent of cretins

treated before the age of six months will reach an IQ of 90 or above, the experience of others is considerably less favorable,[6] and strenuous efforts to diagnose and treat cretinism in the neonatal period are essential in order to give these children a reasonable chance for normal mental development.

Juvenile Myxedema

Juvenile myxedema is hypothyroidism acquired after the first few years of life and may result from failure of functioning remnants of dysgenetic thyroids, decompensation of a previously existing metabolic error or destruction by chronic inflammatory processes such as Hashimoto's Disease. The most conspicuous manifestations are a retardation of linear growth and a delay in physical and sexual maturation. Symptoms such as intolerance to cold, dryness of skin and hair, constipation, increased weight and diminished vigor are generally found. Although cerebration may be slow, these children are frequently good "plodders" and do fairly well in school, insulated from many of the distractions that beset the average school child. Physical examination reveals skin puffiness, dryness and roughness, pallor and carotinemia, as well as other changes which characterize the adult myxedema patient. The pulse is slow and the deep tendon reflexes show the slow relaxation phase characteristic of myxedema.

Laboratory investigation should include a radioactive uptake and scan of the thyroid, as well as some measurement of thyroxin iodine. The cholesterol is almost invariably elevated and the bone age retarded. Unless there is some suggestion of hypopituitarism, a trial of thyroid is indicated without additional study. Failure of a growth spurt to occur after six months is an indication for a pituitary work-up including skull x-ray, thyroid stimulation test (TSH), growth hormone assay and metapirone test. As the period of critical brain development is passed and some risk of Addisonian crisis exists in a hypopituitary child started abruptly on thyroid, a stepwise approach to thyroid replacement is more appropriate in juvenile myxedema.

The response of the patient with acquired hypothyroidism to thyroid replacement is most gratifying, in that growth accelerates, excess weight is lost, the coarseness of the features disappears and vigor is restored. The slowness of the mental responses is replaced by mental alertness. Initially, however, the child's school performance may deteriorate as a greater awareness and responsiveness to distracting stimuli develops, almost as if "blinkers" were removed. As adjustment to the "new" environment occurs, the all-round school performance will generally surpass that during the hypothyroid period, providing that new activities do not make excessive inroads into time reserved for study. The gratifying response to thyroid replacement, available to the young person laboring with the afflictions of juvenile myxedema, provides the physician with another incentive for the early diagnosis of hypothyroidism in children.

The images of the mentally retarded child whose intellect might have been saved by the early diagnosis of cretinism and of the older child restored from juvenile myxedema to a full and active childhood should be retained by every physician caring for children. Hopefully, they will generate the "high index of suspicion" vital to the early detection of thyroid hypo-function.

References

1. Wilkins, L., Thyroid Disorders: 1. Hypothyroidism, Wilkins, L., ed., *The Diagnosis and Treatment of Endocrine Disorders in Childhood and Adolescence,* Springfield, Ill., Charles C. Thomas, Publisher, p 92, 1965.

2. Anderson, H., The Influence of Hormones on Human Development, Falkner, F., ed., *Human Development,* Philadelphia, W. B. Saunders Co., p. 184, 1966.

3. MacMillan, D. R., Endocrine Influences on Fetal Growth, *Ped. Clin. N. Amer.* 17: 111, 1970.

4. Lowrey, G. H., Aster, R. H., Carr, E. A., Roman, G., Beierwaltes, W. H., and Spafford, N. R., Early Diagnosis Criteria of Congenital Hypothyroidism, *Am. J. Dis. Child.* 96: 131, 1958.

5. Hutchison, J. H., Diseases of the Thyroid Gland, Hubble, D. V., ed., *Paediatric Endocrinology,* Philadelphia, F. A. Davis Co., p. 113, 1969.

6. Anderson, H. J., Nongoitrous Hypothyroidism, Gardner, L. I., ed., *Endocrine and Genetic Diseases of Childhood,* Philadelphia, W. B. Saunders Co., p. 216, 1969.

Recurrent Infectious Mononucleosis†

Stuart Graves, Jr., M.D.*

Louisville, Kentucky

A recurrent case of infectious mononucleosis is reported. The young man fulfilled the clinical, hematological and serological criteria for the diagnosis at the age of 22 and again three years later. He was completely well during the interval period.

IF THE diagnosis of infectious mononucleosis is restricted to those cases having the clinical, hematological, and serological findings of the disease, then the recorded cases of recurrent infectious mononucleosis in the literature become very rare indeed.

Hoagland,[1] in his wonderful book based on 500 consecutive cases of infectious mononucleosis studied over a 20 year period, states he has never seen a recurrent case. Bender,[2] in 1962, after searching for 20 years, reported a case of a 28-year-old male student with classical infectious mononucleosis. The patient's heterophil titer was positive 1:1792 and after guinea pig absorption was positive 1:896. Past history of this patient led to a review of a previous hospital record at the age of 23. At that time he had the usual clinical and hematological picture of infectious mononucleosis. The heterophil titer was positive 1:112, but no absorption studies were done.

Kaufman,[3] in 1950 reported 12 cases out of a total series of 125 that he felt had recurrent attacks. His criteria for diagnosis was "at least one typical blood smear with numerous abnormal cells of the mononuclear series plus either a positive heterophil agglutination reaction or a compatible clinical picture or both." He did not state what titer of heterophil agglutination or absorption studies were required. In none of the 12 cases were heterophil agglutinations done on both the first and recurrent episode of the illness. In several cases the initial or recurrent illness was diagnosed by a physician other than the author or by a student health servcie. In case three the author states, "blood smears and agglutination tests were not performed, but there is little doubt that this was a second recurrence of infectious mononucleosis." I do not feel that Kaufman's criteria are adequate for the diagnosis of infectious mononucleosis.

Patterson and Pinniger[4] report cases of recurrent infectious mononucleosis in which some attacks were not documented by hematologic or serologic data.

Isaacs,[5] in an article entitled "Chronic Mononucleosis," states that he had 53 cases out of 206 where symptoms persisted from 3 months to 4 years. The symptoms were fatigue, exhaustion, aching of the legs, weakness, and depression. He reported evening temperature elevations from 99.8 to 101, splenomegaly, depressed blood pressure, depressed blood sugar, and a depressed urine specific gravity. He states that all cases had infectious mononucleosis cells in the peripheral smear of the "mature type" and that these ranged from 1 to 7% of the total white blood cell count. In no case was the heterophil agglutination titer higher than 1:64. Some of these cases might be considered to be recurrent infectious mononucleosis; but again I feel that his criteria are not sufficient for a definite diagnosis of the disease.

The following case would seem to fulfill the clinical, hematological and serological criteria for infectious mononucleosis in the initial and recurrent attack. It is therefore reported because of its rarity and because of the difficulty that it posed for the physician, who assumed that recurrent infectious mononucleosis did not occur.

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**Associate Clinical Professor of Medicine, University of Louisville School of Medicine*

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Report of a Case

A 22-year-old predental student was hospitalized on 3-4-67 with an eight-day history of severe chills, fever, sore throat, headache and malaise. Two days before admission he had some nausea and occasional vomiting. His past health had always been excellent. Physical examination revealed an acutely ill dehydrated young male. His temperature was 101 p.o. There was lymphadenopathy of the cervical, axillary and inguinal areas. The liver and spleen were not palpable. The hemoglobin was 15.2 grams% and the WBC was 12,300 with neutrophils 44%, eosinophils 1%, monocytes 2%, lymphocytes 13%, and atypical lymphocytes 40%. The mono test was strongly positive. The chest film, VDRL, and urinalysis were all normal. Liver function tests revealed an SGOT of 156 units, total bilirubin of 0.6mg%, and a cephalin flocculation of 3+ in 24 and 48 hours. Four subsequent WBC's ranged from 16,500 to 13,200 with atypical lymphocytes of 51%, 44%, 54% and 48%. The neutrophil counts were 44%, 31%, 33% and 26% respectively. The patient was treated with prednisone with excellent results and discharged 13 days after admission on no medications and asymptomatic.

The patient was next seen one month prior to his second admission with vague upper abdominal distress and no positive physical findings. No treatment was given.

On 5-15-70 he was again hospitalized with a five-day history of severe headache, chills, fever, anorexia, nausea and occasional vomiting after eating. His temperature was 102.6 p.o. and he appeared acutely ill. There was a slight cervical and more marked inguinal lymphadenopathy. The rest of the physical examination was normal. The admitting blood count revealed a hemoglobin of 16.3 grams %, WBC 7,000 with neutrophils 45%, eosinophils 10%, monocytes 6%, lymphocytes 32% and atypical lymphocytes 7%. The mono test was negative. Urinalysis SGOT, total bilirubin, alkaline phosphatase, VDRL and chest film were all normal on admission.

In spite of the suggestive clinical and hematological findings for a diagnosis of infectious mononucleosis, it was not seriously considered because of the feeling that recurrent infectious mononucleosis did not occur. Some small comfort was obtained from the negative mono test.

The patient continued to have a hectic febrile course and was treated only with analgesics. Multiple studies were done to establish a diagnosis. Agglutinations for brucella abortus, proteus OX-19, paratyphoid A and B, and typhoid O and H were normal. A thick blood smear for malaria, LE cell preparation, electrophoretic protein study, 3 stools for ova and parasites, 3 blood cultures, serum amylase, and sedimentation rate were all negative or normal. Gallbladder and upper gastorintestinal x-rays were normal. Bone marrow examination revealed no abnormality except slight eosinophilic hypercellularity. The erythrocytic series, platelets, megakaryocytes, plasmacytes and reticulum cells appeared normal. No parasites or foreign body cells were found. Bone marrow cultures were negative on multiple media. Lymph node biopsy revealed only slight hyperplasia with no specific type of reaction. Muscle biopsy was normal.

On the ninth day of hospitalization the WBC was 15,000 with neutrophils 29%, eosinophils 14%, monocytes 2%, lymphocytes 39% and atypical lymphocytes 16%. On the eleventh and thirteenth hospital days the mono test was positive. At this time the heterophil agglutination was positive 1:112 and with guinea pig absorption was positive 1:14. There was no agglutination after absorption with beef erythrocytes. On the eighteenth hospital day the WBC was 20,400 with neutrophils 35%, eosinophils 3%, monocytes 9%, lymphocytes 19%, and atypical lymphocytes 32%.

After the diagnosis of infectious mononucleosis was finally made the patient was started on prednisone therapy with an excellent clinical response. The drug was reduced in a step-wise manner and he was discharged on 6-6-70 on 10 mg. of prednisone daily.

A WBC on 6-12-70 was 13,100 with neutrophils 26%, monocytes 2%, eosinophils 3%, lymphocytes 59% and atypical lymphocytes 10%. All therapy was stopped and on 6-26-70 the patient was asymptomatic with a WBC of 11,400. The neutrophils were 45%, monocytes 5%, eosinophils 8%, lymphocytes 38% and atypical lymphocytes 7%.

Comment

Until very recently, all attempts at identifying the etiologic agent or agents of infectious mononucleosis were unsuccessful. In 1968, several groups of workers[6, 7, 8] demonstrated a relationship between patients with infectious mononucleosis and the Epstein-Barr virus (EBV). If the EBV is proven to be the cause of infectious mononucleosis and if the observation made by Lehane[9] and others that the presence of EBV antibodies prevents the development of clinical infectious mononucleosis, this would explain why recurrent cases are so rare. Further work in this area will be awaited with great interest.

Undoubtedly, many cases of infectious mononucleosis are falsely diagnosed. The mother's statement that her child "has had infectious mono three times" is all too familiar. It is a very socially acceptable disease in this era and is almost sure to excuse the patient from two to six weeks of school. On the other hand, as reported here, it apparently can recur, even using the strictest criteria.

References

1. Hoagland, R. J., *Infectious Mononucleosis,* New York, Grune and Stratton, 1967.

2. Bender, C. E., Recurrent Mononuclesosis, *JAMA* 182:954-956, 1962.

3. Kaufman, R. E., Recurrences in Infectious Mononucleosis, *Amer. Pract. Digest Treat.* 1:673-676, 1950.

4. Paterson, J. K., Pinniger, J. L., Recurrent Infectious Mononucleosis, *Brit. Med. J.* 2:476, 1955.

5. Isaacs, R., Chronic Mononucleosis, *Blood* 3:858-861, 1948.

6. Henle, G., Henle, W., Diehl, V., Relation of Burkitt's Tumor-Associated Herpes-type Virus to Infectious Mononucleosis, *Proc. Nat. Acad. Sci. USA* 59:94-101, 1968.

7. Niederman, J. C., McCollum, R. W., Henle, G., et al, Infectious Mononucleosis: Clinical Manifestations in Relation to EB Virus Antibodies, *JAMA* 203:205-209, 1968.

8. Evans, A. S., Niederman, J. C., McCollum R. W., Seroepidemiologic Studies of Infectious Mononucleosis with EB Virus, *New Eng. J. Med.* 279:1121-1127, 1968.

9. Lehane, D. E., A Seroepidemiologic Study of Infectious Mononucleosis, *JAMA* 212:2240-2242, 1970.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in the Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.



Thank You

The Journal approaches its sixty-eighth Christmas this month. For all of us the year past has been an eventful one, and we welcome the year-end holiday season as a bit of a respite, and a chance to review our course. We at *The Journal of the Kentucky Medical Association* well know how much we are indebted to others for the success of this past year, and take pleasure in acknowledging their contributions herewith.

Many fine scientific articles have been published, including further items in the continuing series entitled "Medical Progress." Our thanks, too, to the scientific editorial consultants; their largely unsung labors of love, in reading and commenting on papers submitted, form a core around which this *Journal* is built.

Several physicians have contributed special articles, some have been regular columnists, and many have helped us along with news items of interest. To all of these doctors we are indebted.

For their very real advice and counsel we extend our appreciation, also, to the administration and faculty of each of the medical schools in Kentucky. They form a base upon which our medical culture, heritage and education can grow, and they have been consistently helpful and cooperative. For this pleasant relationship we are grateful.

To the companies whose advertising has been presented on these pages, we offer our thanks for their confidence and support. Such support enables us to present, with reasonable economy, the ongoing story of Kentucky medicine to its participants — you, the physicians of this state. We appreciate that opportunity.

To all these people — to all involved in any way in the fascinating and complex process of medical care in Kentucky this past year — we say well done. Thank you for our efforts. May your frustrations diminish and your peace of mind increase.

Merry Christmas.

WALTER I. HUME, JR., M.D.

JOURNEY'S END

When on my day of life the night is falling,
And, in the wind from unsunned spaces blown,
I hear far voices out of darkness calling
My feet to paths unknown;

Thou, who hast made my home of life so pleasant,
Leave not its tenant when its walls decay;
O Love Divine, O Helper ever present,
Be Thou my strength and stay.

I have but Thee, my Father! let Thy Spirit
Be with me then to comfort and uphold;
No gate of pearl, no branch of palm I merit,
Nor street of shining gold.

Suffice it if — my good and ill unreckoned,
And both forgiven thro' Thine a-bounding grace —
I find myself by hands familiar beckoned
Unto my fitting place,

Some humble door among Thy many mansions,
Some sheltering shade where sin and striving cease,
And flows forever through heaven's green expansions
The river of Thy peace.

There, from the music round about me stealing,
I fain would learn the new and holy song,
And find at last, beneath Thy trees of healing,
The life for which I long.

John Greenleaf Whittier (1807-1892)

Deceased Kentucky Physicians

1970*

Salvador Adriano, Erlanger
Alexander John Alexander, Lexington
Moses Algaze, Ashland
Omar Copeland Amstutz, Irvine
George Fielding Ballard, Harrodsburg
James Dudley Banta, Lexington
Leonard S. Berman, Maysville
Max Ewart Blue, Richmond
Martin Harold Boldt, Louisville
Horace Signor Brannon, Covington
Allen Burgess Carter, Paintsville
Willie Farmer Carter, Pleasureville
Claud Wilbur Chappell, Louisville
Garland Hunt Clark, Winchester
William C. Cloyd, Richmond
Armand Earl Cohen, Louisville
Thomas Benton Coleman, Louisville
Ward Louis Corum, Louisville
Irwin H. Cutler, Louisville
Herbert G. Davis, Glasgow
Tracy I. Doty, Pikeville
Kathryn C. Epple, Mexico, Mo.
Lawrence K. Epple, Mexico, Mo.
Max Ervin, Louisville
Ernest Morrison Ewers, Nashville, Tenn.
Clifton George Follis, Glasgow
Winfield S. Gabhart, Harrodsburg
Lawrence Ullis Gilliam, Corbin
William Albert Graham, Flemingsburg
Thomas A. Griffith, Simpsonville
Allen Evans Grimes, Lexington
Charles E. Hall, Pikeville
Fred Turnley Harned, Jr., Hopkinsville
Rex Edward Hayes, Glasgow
Charles Bowman Johnson, Russell
Arch D. Kennedy, Louisville
Paul A. Keeney, Louisville
Oscar Oswald Miller, Louisville
Charles Thomas Moran, Louisville
William Gregory Morgan, Owensboro
W. B. Negley, Maceo
Perry Overby, Mt. Olivet
James L. Patterson, Wheelwright
James A. Payne, Louisville
Clark Bascom Pergrem, Elkhorn City
John W. Price, Jr., Louisville
Robert L. Rainey, Louisville
Grant Rice, Oil Springs
Wallace Edward Rich, Louisville
Rob Gibson Richardson, Somerset
Leslie M. Ringel, Covington
John Hunt Rutledge, Hazard
William Jack Schutz, Louisville
Price Sewell, Jr., Jackson
William J. Smith, Belfry
Ben Wilson Smock, Louisville
John Stites, Louisville
LaVern L. Swigart, Williamson, W. Va.
Lawrence A. Taugher, Louisville
Eugene Todd, Jr., Lexington
Roy Waddell, Salem
James E. Winter, Dallas, Texas
Benjamin Franklin Wright, Seco
Walter S. Wyatt, Lexington
Allan Frey Zoeller, Louisville

**List of names of deceased physicians available to The Journal as of November 15, 1970.*

Letters To The Editor

The Letters To The Editor column is a means for the KMA physicians to express their opinions and viewpoints on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Letters To The Editor, Kentucky Medical Association, 3532 Ephraim McDowell Dr., Louisville, Kentucky 40205. Communications should not exceed 250 words. The right to abstract or edit is reserved by the editors of *The Journal*. Names will be withheld upon request, but anonymous letters will not be accepted.

EDITOR'S NOTE: The following letter was received by Lewis Dickinson, M.D., insurance editor, in response to the Insurance Page that appeared in the October, 1970, issue of The Journal.

Dear Editor:

While I thank you for the clipping you sent me of your editorial in *The Journal of the Kentucky Medical Association,* I am surprised at your characterization of Mr. Tunley's article on pre-paid group medical insurance in the August *American Legion Magazine.*

Mr. Tunley *reported* the pressure on Capitol Hill for a national health plan. You had better believe it is there—in fact you do believe it, you know it.

But what he spoke in favor of was the general shape of the Kaiser plan. The Kaiser plan is private medicine, run by a corporate entity of doctors, now close to 40 years old. Far from being a socialistic system, the Kaiser plan is a form of double capitalism. At its heart, the doctors have become insurers too, so they are running both a medical and an insurance corporation—and reaping the benefits of both at less cost to patients by the elimination of third party insurers.

If you are astounded that we should publish Tunley's warm appraisal of this effective private system, which shows what can be done for medicine if it employs modern management techniques, imagine how astounded I am that you should think this is a pitch for socialism.

You cannot find one word in Mr. Tunley's article in behalf of national health insurance. You *can* find a passage in which he reports that its proponents look upon the outlines of the Kaiser plan as a management technique which they count on to make socialized medicine work. I think it is evident from Mr. Tunley's article that prepaid group insurance may be the last hope of private medicine to forestall the pell-mell rush toward a national health plan now under way in Washington.

I hope you can find space in *The Journal of the Kentucky Medical Association* to publish this letter of mine, in all fairness to myself, Mr. Tunley, the Legion, and the members of the Kentucky Medical Association.

Robert B. Pitkin
Editor
The American Legion Magazine

In Memoriam

MARTIN H. BOLDT, M.D.
Louisville
1917 - 1970

Martin H. Boldt, M.D., an internist, died September 18 at the age of 53. Doctor Boldt got his medical degree from Columbia University in 1943. He was an associate professor of medicine at the University of Louisville School of Medicine, a past president of the Louisville Society of Internists and served on the American Board of Internists.

WALLACE EDWARD RICH, M.D.
Louisville
1892 - 1970

Wallace Edward Rich, M.D., a specialist in psychiatry, died September 18 at the age of 78. Doctor Rich was the first superintendent of the Kentucky State Hospital at Danville. He joined the staff of the Eastern State Hospital in Lexington in 1952 where he served until his retirement in 1969. He was a member of the Fayette County Medical Society, the Kentucky and American Medical Associations and the Kentucky and American Psychiatric Associations.

JOHN STITES, M.D.
Louisville
1905-1970

John Stites, M.D., Louisville, a specialist in internal medicine, died at the age of 65 on October 20. Doctor Stites, a graduate of the University of Louisville Medical School, had retired from practice in 1963 because of ill health. He served in the U. S. Army from 1941 to 1946, 30 months of this time overseas, and then returned to Louisville to practice in association with his brother, Frank M. Stites Jr., M.D.

ORGANIZATION SECTION

KEMPAC Directors Elect Doctors Peters, Rainey, Stewart



Doctor Peters



Doctor Rainey

C. Kenneth Peters, M.D., Louisville, was re-elected chairman of the KEMPAC Board of Directors at its annual meeting November 12. Fred C. Rainey, M.D., Elizabethtown, was re-elected vice-chairman. John P. Stewart, M.D., Frankfort, was newly elected to the office of secretary-treasurer.



Doctor Stewart

Doctor Stewart, who has represented the Sixth Congressional District on the KEMPAC Board for the last four years, attended the University of Pennsylvania Medical School, served his internship and residency in radiology at the University of Michigan and has been in private practice in Frankfort since 1956.

A new member-at-large of the KEMPAC Board is Mrs. William E. Pearson, Owensboro, who is one of the representatives of the Woman's Auxiliary to KMA.

A workshop for KEMPAC Board members, the KMA Executive Committee and the KMA Committee on Legislative Activities was discussed at the November 12 meeting. The workshop, designed to establish guidelines for KEMPAC and to explore ways to expand membership, is scheduled for early in 1971. The date and place of the workshop will be announced at a later date.

Specialty College Recognizes Achievements Of Area Doctors

The American College of Physicians recently recognized several Kentucky members by granting them Fellowship or Membership in the 54-year-old international specialty society. The college dedicates itself to upgrading medical care, teaching, and research through stringent standards of membership and programs of continuing education.

Kentuckians so honored include: Fellowships—Howard B. McWhorter, M.D., Ashland; James W. Hollingsworth, M.D., and John W. Schaefer, M.D., of Lexington; Alan M. Bornstein, M.D., Daniel E. Leb, M.D., and Elliott Podoll, M.D., all of Louisville. Elected to Membership were: David J. Brecount, M.D., Leonard S. Gettes, M.D., and Wayne W. Peternel, M.D., of Lexington; and Norman Glazer, M.D., John N. Goldsborough, M.D., Temple B. Stites, M.D., Walter L. Thompson, M.D., and Frank W. Lehn, M.D., of Louisville.

The American College of Physicians now has 16,000 members and is a pioneer in post-graduate courses and other means for continuing education.

General Practice Departments Planned For Medical Schools

A law requiring the University of Louisville School of Medicine and the University of Kentucky College of Medicine to set up departments of general practice was passed by the last Kentucky Legislature. Progress is being made to implement this law at both medical schools.

The U. of L. Medical Council, at a recent meeting, voted unanimously to establish a department of general or family practice at the earliest possible date. The Council authorized Dean Douglas Haynes, M.D., Louisville, to form a committee to find a chairman for the department.

The U. of K. College of Medicine is also making progress toward establishing a similar department, according to Ben F. Roach, M.D., Midway, who is president of the Kentucky Academy of General Practice and a member of a seven-man committee appointed by the U. of K. Medical School Dean, William S. Jordan, Jr., M.D., Lexington, to plan a department of general practice.

Cancer Treatment Symposium To Be Held January 23

Authorities in the fields of surgery, radiotheraphy, otolaryngology and oral pathology will participate in a symposium on "Recent Advances in the Treatment of Head and Neck Cancer," January 23, 1971, in the Health Sciences Library, Health Sciences Center, University of Louisville.

Sponsored by the Department of Surgery, University of Louisville School of Medicine, in conjunction with the School of Dentistry, it will be from 9:00 a.m. to 1:00 p.m., with registration at 8:45. It is supported by the American Cancer Society, Kentucky Division, and in part by the Ohio Valley Regional Medical Program.

The symposium is open to all physicians, dentists, house physicians and related groups. There is no registration fee. Credit hours have been applied for from the American Academy of General Practice, Kentucky Division. Four credit hours will be given by the Academy of General Dentistry for Continuous Education.

Academy Of Pediatrics Calls For Council On Children

The American Academy of Pediatrics called, during their recent national meeting, for the formation of a National Advisory Council on Children which would be responsible to the President of the United States. The Academy also called for the creation of a voluntary multidisciplinary national health service corps, and a national health insurance program to insure comprehensive coverage for all children.

These were among the recommendations made by the AAP in a special study on the delivery of health care to children. This report called for an expansion in the supply of physicians; an increase in enrollment in medical schools; an increase in scholarships, loans and other methods of tuition financing for medical schools; expanded and well-funded residency programs for the training of primary care physicians; and adequate funding for medical schools.

Health Conference, March 25-26

The 24th National Conference on Rural Health will be held March 25-26 in Atlanta, Georgia. The theme of the meeting, sponsored by the Council on Rural Health, American Medical Association, will be "Community Health Programs for Tomorrow."

Among the outstanding speakers scheduled is Vernon E. Wilson, M.D., administrator of the Health Services and Mental Health Administration of the Department of Health, Education and Welfare, who will speak on "Rural Health Care Systems." "Medical School Involvement in Community Medicine" will be the topic of Hugh S. Fulmer, M.D., of the University of Massachusetts Medical School.

Resolution On Amphetamines

Amphetamines was the subject of a resolution passed by the 1970 House of Delegates. Members of the KMA Executive Committee felt that it was a timely and significant matter that should be brought to the attention of *The Journal* readers. The resolved read as follows:

> "The members of the Kentucky Medical Association reaffirm their belief that these dangerous drugs should be prescribed with utmost care only for very limited specific indications as outlined by the American Medical Association Council on Drugs and Therapeutics."

Henderson County Resolution

The Henderson County Medical Society recently resolved that the organization would "petition the Kentucky Department of Highways to take all reasonable action to prevent the continuation of serious motor vehicle accidents on U. S. Highway 41 in the area between the North Cloverleaf and the Evansville bridges."

Copies of this Resolution have been sent to the Kentucky Commissioner of Highways, the U. S. Bureau of Roads, Department of Transportation, the Mayor and Commissioners of the City of Henderson, the Judge and Magistrates of Henderson County and to the local news media.

Learning System Announced

MEDCOM, Inc. recently announced a complete medical learning system on the subject of depression. This continuing education project, provided as a service by a pharmaceutical company, consists of a documentary film, a comprehensive monograph and a self-evaluation section.

It is available for use by county program chairmen, hospital staff program chairmen and all other interested physicians. Anyone wanting further information on the project should contact the KMA Headquarters Office.

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NEWS ITEMS

William M. Carney, M.D., has recently completed his residency in pathology and joined Laszlo Makk, M.D., and Herbert Dickstein, M.D., in practice in Louisville. Doctor Carney graduated from the University of Louisville and interned and served his residency at Louisville General Hospital.

John T. Sullivan, M.D., has joined J. C. Cantrill, M.D.; R. K. Brown, M.D.; and D. V. Hollingsworth, M.D., in practice in Georgetown. A graduate of the Tulane University Medical School, Doctor Sullivan interned at the United States Public Health Service Hospital in New Orleans.

Lewis P. Hicks, M.D., is currently with the Kentucky Department of Health. He graduated from the University of North Carolina Medical School, interned at the University of Kentucky and has served with the U.S. Army.

Alejandro G. Pontaoe, M.D., has recently joined the staff of the Western State Hospital in Hopkinsville. He practiced psychiatry in the Philippines from 1964 to 1969 and was staff phychiatrist at Western State Hospital in Virginia from 1969 until he came to Kentucky.

William Powers, M.D., is now practicing with B. P. Smith, M.D., in Hawesville. He graduated from the University of Louisville, interned at Orange, California, and served with the U.S. Army before coming to Kentucky.

W. A. Warner, M.D., has joined the staff of the University of Kentucky Medical Center in Lexington. A specialist in the fields of pulmonary medicine and anesthesiology, Doctor Warner has been on the faculty of the University of Iowa and the University of Florida.

Walter D. Harris, M.D., has recently completed a tour of duty with the U.S. Army and is practicing in association with H. L. Reams, M.D., Lexington. Doctor Harris is specializing in otolaryngology.

Phyllis D. Corbitt, M.D., a general practitioner, is now associated with Dale E. Dunkelberger, M.D., in Wilmore. Doctor Corbitt graduated from and interned at the Vanderbilt University Medical School. She has served as a medical missionary in Africa.

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Meeting Announced

The Northern Kentucky Eye, Ear, Nose and Throat Society recently announced that it will meet every first Thursday of the month at the time of the Campbell-Kenton Medical Society meeting.

The present officers are Alvin C. Poweleit, M.D., F.A.C.S., Covington, president; Robert C. Kratz, M.D., Newport, vice-president; and Robert L. Strawn, M.D., Covington, secretary-treasurer.



December 14

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In Memoriam

IRWIN H. CUTLER, M.D.
Louisville
1893-1970

Irwin H. Cutler, M.D., 76, a recently retire Louisville physician, died November 2. A native o Chicago, Doctor Cutler was a graduate of the Uni versity of Illinois College of Medicine. He has bee in general practice in Louisville for many years Doctor Cutler was a member of the Jefferso County Medical Society and the Kentucky an American Medical Associations.

WILLIAM C. CLOYD, M.D.
Richmond
1913-1970

William C. Cloyd, M.D., 57, a general practitione in Richmond for several years, died November 3 He was the medical advisor to the Richmond Selec tive Service Board for 25 years. A native of Camp bellsville, Doctor Cloyd was a graduate of the Uni versity of Louisville School of Medicine. He wa active in Boy Scout work and a member of th Madison County Medical Society and the Kentucky and American Medical Associations.

PRICE SEWELL JR., M.D.
Jackson
1913-1970

Price Sewell Jr., M.D., 57, a general practitione in Breathitt County, died November 14. A graduat of the Vanderbilt University School of Medicine Doctor Sewell was chairman of the Breathitt County Board of Health and a member of the Jackson City School Board of Education.

WALTER S. WYATT, M.D.
Lexington
1883-1970

Walter S. Wyatt, M.D., a Lexington physican for almost half a century, died November 10 at the age of 87. He started practice in Lexington in 1911 and joined the Lexington Clinic in 1920. He practiced medicine full time until 1954 and then part-time until retiring in 1957. One of the state's first specialists in gastroenterology, Doctor Wyatt received his M.D. degree from Johns Hopkins University and did post-graduate work at Lakeside Hospital in Cleveland and Boston City Hospital.

WILLIAM J. SCHUTZ, M.D.
Louisville
1906-1970

William J. Schutz, M.D., 64, president of the Louisville Eye Society, died October 23, 1970. An associate professor at the University of Louisville Medical School, he was an ophtalmologist. Doctor Schutz was a member of the national, state and county medical associations, American Academy of Ophthalmologists, a fellow of the American College of Surgeons and a diplomat of the American Board of Ophthalmology.

The J. A. Ouchterlony Memorial Meeting of The Kentucky Medical Association

Terrace Room, Kentucky Hotel, Louisville, Kentucky, September 22-24, 1970

Digest* of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Richard F. Greathouse, M.D., Louisville
Speaker of the House, Presiding

First Session

Speaker Greathouse called the 120th Meeting of the KMA House of Delegates to order at 9:15 a.m. and asked Paul Parks, M.D., Bowling Green, to give the invocation. He announced that J. Sankey Williams, M.D., Nicholasville, Chairman of the Credentials Committee, was not able to be in attendance at this meeting and called on Charles C. Kissinger, M.D., to give the report of the Credentials Committee. Doctor Kissinger reported that a quorum was present. A motion was made, seconded, and passed that the minutes of the 1969 session of the House of Delegates be approved as published in the December, 1969, *Journal of the Kentucky Medical Association.*

S. R. Scheen, M.D., Louisville, Secretary, presented the general announcements. He called attention to the scientific sessions beginning at 8:50 a.m. on Tuesday, September 22, at the Convention Center. He emphasized that the highlight of the meeting, the President's Luncheon, would be held on Wednesday and feature Mr. Ralph Lee Smith, author of *At Your Own Risk.* Doctor Scheen reminded the delegates that the six reference committees would convene at 2:00 p.m., Monday, in various rooms on the mezzanine floor of the Kentucky Hotel and that the Nominating Committee for general officers would meet at the close of this first session of the House. Doctor Scheen concluded his announcements by reminding the delegates to use the Message Center and to visit the technical and scientific exhibits during this year's Annual Meeting.

Doctor Scheen then read the list of physicians who had died since the 1969 meeting of the House of Delegates, following which the members of the House stood for a moment of silent tribute. The names of these physicians, their locations, and dates of death were given as follows:

Adriano, Salvador	Erlanger	Nov. 3, 1969
Alexander, Alexander John	Lexington	Nov. 18, 1969
Algaze, Moses	Ashland	Feb. 2, 1970
Baker, Everett Harold	Louisville	Sept. 18, 1969
Ballard, George Fielding	Harrodsburg	Feb. 22, 1970
Banta, James Dudley	Lexington	May 7, 1969
Blue, Max Ewart	Richmond	Jan. 15, 1970
Brannon, Horace Signor	Covington	Unknown
Burkhart, Henry C.	Harlan	Sept. 29, 1969
Carter, Allen Burgess	Paintsville	Mar. 24, 1970
Carter, Willie Farmer	Pleasureville	Dec. 21, 1969
Chappell, Claud Wilbur	Louisville	Jan. 2, 1970
Clark, Garland Hunt	Winchester	Jan. 27, 1970
Cohen, Armand Earl	Louisville	April 23, 1970
Coleman, Thomas Benton	Louisville	Feb. 13, 1970
Corum, Ward Louis	Louisville	Mar. 24, 1970
Davis, Herbert G.	Glasgow	Dec. 31, 1969
Doty, Tracy I.	Pikeville	Aug. 23, 1969
Epple, Kathryn C.	Mexico, Mo.	July 24, 1969
Epple, Lawrence K.	Mexico, Mo.	July 24, 1969
Ervin, Max	Louisville	July 1, 1970
Ewers, Ernest Morrison	Nashville, Tenn.	Unknown
Follis, Clifton George	Glasgow	Jan. 12, 1970
Gabhart, Winfield S.	Harrodsburg	June 11, 1969
Gilliam, Lawrence Ullis	Corbin	Feb. 25, 1970
Graham, William Albert	Flemingsburg	Aug. 23, 1969
Griffith, Thomas A.	Simpsonville	Unknown
Grimes, Allen Evans	Lexington	April 5, 1970
Hall, Charles E.	Pikeville	Sept. 2, 1969
Harned, Fred Turnley, Jr.	Hopkinsville	April 1, 1970
Hayes, Rex Edward	Glasgow	Dec. 10, 1969
Kennedy, Arch D.	Louisville	Aug. 5, 1970
Keeney, Paul A.	Louisville	July 17, 1970
Kirby, Thomas	Bowling Green	Sept. 13, 1969
Miller, Oscar Oswald	Louisville	Feb. 12, 1970
Moran, Charles Thomas	Louisville	April 18, 1970
Morgan, William Gregory	Owensboro	Jan. 17, 1970
Negley, W. B.	Maceo	Mar. 18, 1970
Overby, Perry	Mt. Olivet	May 2, 1970
Payne, James A.	Louisville	Dec. 24, 1969
Pergrem, Clark Bascom	Elkhorn City	Nov. 30, 1969
Price, John W., Jr.	Louisville	Feb. 25, 1970
Rainey, Robert L.	Louisville	Aug. 5, 1970
Rice, Grant	Oil Springs	April 1970
Richardson, Rob Gibson	Somerset	Unknown
Ringel, Leslie M.	Covington	Sept. 12, 1969
Rutledge, John Hunt	Hazard	Sept. 27, 1969
Smith, William J.	Belfry	June 29, 1969
Smock, Ben Wilson	Louisville	Jan. 1, 1970
Swigart, LaVern L.	Williamson, W. Va.	Mar. 7, 1970
Taugher, Lawrence A.	Louisville	July 7, 1970
Todd, Eugene, Jr.	Lexington	Feb. 22, 1970
Waddell, Roy	Salem	April 24, 1970
Wilson, Laban Robbins	Franklin	June 5, 1969
Winter, James E.	Dallas, Texas	July 7, 1970
Wright, Benjamin Franklin	Seco	Aug. 11, 1969
Zoeller, Allan Frey	Louisville	June 6, 1970

Doctor Greathouse then announced the reference committee appointments as follows:

Reference Committee No. 1

Harold L. Bushey, M.D., Barbourville, Chairman
Glenn F. Baird, M.D., Florence

Editorial Note: A tape recording was made of the two sessions of the House of Delegates, and any member who desires to examine the transcript of these proceeding may visit the Headquarters Office and listen to the recording.

Winston L. Burke, M.D., Lexington
Frank M. Gaines, Jr., M.D., Louisville
Walter R. Johnson, M.D., Paducah

Reference Committee No. 2

Faull S. Trover, M.D., Madisonville, Chairman
Peter P. Bosomworth, M.D., Lexington
Harry B. Huntsman, II, M.D., Greensburg
Edwin P. Solomon, Jr., M.D., Louisville
James O. Willoughby, M.D., Bowling Green

Reference Committee No. 3

Cecil L. Grumbles, M.D., Louisville, Chairman
Carl J. Brueggemann, M.D., Covington
Jerry D. Fraim, M.D., Paintsville
John P. Hill, Jr., M.D., Somerset
John S. Oldham, M.D., Owensboro

Reference Committee No. 4

Thomas L. Heavern, M.D., Highland Heights, Chairman
Braham B. Baughman, M.D., Frankfort
Leslie W. Blakey, M.D., Lexington
W. Neville Caudill, M.D., Louisville
Hugh L. Houston, M.D., Murray

Reference Committee No. 5

Glenn W. Bryant, M.D., Louisville, Chairman
Thomson R. Bryant, M.D., Lexington
Billy G. Jackson, M.D., Princeton
Stephen B. Kelly, M.D., Somerset
Raymond D. Wells, M.D., Inez

Reference Committee No. 6

John F. Berry, Jr., M.D., Lexington, Chairman
George P. Archer, M.D., Prestonsburg
James B. Cox, M.D., Hopkinsville
Edward N. Maxwell, M.D., Louisville
W. Vinson Pierce, M.D., Covington

The Speaker reported that the tellers for the meeting would be Edward C. Bowling, M.D., Stanford, Chairman; C. Douglas LeNeave, M.D., Mayfield; and Earl P. Oliver, M.D., Scottsville.

Doctor Greathouse named the physicians on the Nominating Committee as follows: W. E. Becknell, M.D., Manchester, Chairman; Clyde Brassfield, M.D., Elizabethtown; Thomson R. Bryant, Jr., M.D., Lexington; W. Fielding Rubel, M.D., Louisville; Sandford L. Weiler, M.D., Frankfort.

The reports of the officers and committees were presented by the Speaker and then referred to the respective reference committees as follows: (Only the reports of the officers were read.)

Report of the President—Reference Committee No. 1 with the following exception: Paragraphs 11 and 12 on page 3 and ending on page 4 of the Reports Booklet referred to Reference Committee No. 6.

At this time, Doctor Cawood combined his Annual Report of the President and the Presidential Address in one presentation.

Report of the President, Woman's Auxiliary to KMA—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

As part of his report, Doctor Quertermous submitted the following resolution from the Calloway County Medical Society which was unanimously adopted by the House:

WHEREAS, Ora K. Mason, M.D., was taken from us on September 20, 1970, and

WHEREAS, she had been for nearly fifty (50) years a conscientious and dedicated physician, and

WHEREAS, she gave unselfishly of her time, her talents and her energies to her patients, her community and this State, and

WHEREAS, she and her physician husband were innovative and dedicated to the progress of medicine in Kentucky, and now therefore be it

RESOLVED, that the Kentucky Medical Association meeting in Louisville, Kentucky, at its 120th Annual Session hereby offer our deep and abiding sympathy to the family of Doctor Ora K. Mason, and be it further

RESOLVED, that this resolution become an official part of the proceedings of this 120th Annual Meeting and a copy of the said resolution be forwarded to the family of Doctor Mason with an expression of our gratitude for her service and dedication to the medical profession, to her patients and to all the people of this Commonwealth.

Doctor Greathouse announced that the Chairman of the KMA Awards Committee, Richard F. Grise, M.D., Bowling Green, would now present his committee's report to the House. Doctor Grise stated that his committee's responsibility was to nominate individuals for the Outstanding General Practitioner Award and the Distinguished Service Medal. Bush A. Hunter, M.D., Lexington, was nominated for the Outstanding General Practitioner Award. A motion was made, seconded and carried to accept this nomination and confer the award upon Doctor Hunter. William R. Willard, M.D., Lexington, was nominated for the Distinguished Service Medal; following which a motion was made, seconded, and carried to accept the nomination and confer the medal upon Doctor Willard.

The Speaker then continued with the referrals of reports to the reference committees.

Report of the Speaker of the House—Reference Committee No. 1

Report of the Chairman, Board of Trustees—Reference Committee No. 1 with the following exceptions: The Comprehensive Health Planning Committee Report, on page 8 of the Reports Booklet, referred to Reference Committee No. 5; the Finance Committee Report, page 8, referred to Reference Committee No. 6; the Occupational Pulmonary Disease Committee Report, page 9, referred to Reference Committee No. 3; the Emergency Medical Care Planning Committee Report, page 9, referred to Reference Committee No. 2; and the Ad Hoc Chiropractic Committee Report, page 9, referred to Reference Committee No. 5.

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to AMA—Reference Committee No. 1

Report of the Executive Director—Reference Committee No. 1

At this time, Doctor Greathouse announced that in keeping with a Board of Trustees recommendation, the president of each of the Student AMA Chapters had been invited to present an oral report to the House. He then called Mr. Phil Mayer, President of the University of Louisville School of Medicine SAMA Chapter, to the podium for his report. Following Mr. Mayer's presentation, the Speaker asked Mr. Bob Cooper, representing the University of Kentucky College of Medicine SAMA Chapter, to come forward to present his report to the members of the House.

The reports of the medical students were very well received by the House, and Doctor Greathouse commended each on his presentation.

The Kentucky State Association of Medical Assistants served coffee and sweet rolls to the members of the House at 10:25 a.m. in the rear of the Terrace Room.

The Speaker then continued with the referrals of reports to the reference committees:

Report of the Judicial Council—Reference Committee No. 6

Report of the Rural Kentucky Medical Scholarship Fund—Reference Committee No. 6

Report of the Board of Directors, Kentucky Physicians Mutual, Inc.—Reference Committee No. 4

Report of the Scientific Program Committee—Reference Committee No. 2

Report of the Scientific Exhibits Committee—Reference Committee No. 2

Report of the Committee on Medical Education—Reference Committee No. 2

Report of the Hospital Committee—Reference Committee No. 2

Report of the Committee on Educational Television—Reference Committee No. 2

Report of the Disaster Medical Care Committee—Reference Committee No. 2

Report of the Cancer Coordinating Committee—Reference Committee No. 2

Report of the Advisory Committee to Blue Shield—Reference Committee No. 4

Report of the Advisory Committee to Blue Cross—Reference Committee No. 4

Report of the Committee on Occupational Health, Physical Medicine, and Rehabilitation—Reference Committee No. 3

Report of the Maternal Mortality Study Committee—Reference Committee No. 3

Report of the Advisory Committee to Selective Service—Reference Committee No. 5

Report of the Committee to Study the Constitution and Bylaws—Reference Committee No. 6

Report of the Interim Meeting Program Committee—Reference Committee No. 6

Report of the McDowell House Board of Managers—Reference Committee No. 6

Report of the Memorials Commission—Reference Committee No. 6

Report of the Committee on Legislative Activities—Reference Committee No. 3 with the following exception: The last paragraph on page 33 and paragraphs 1 and 2 on page 34 of the Reports Booklet referred to Reference Committee No. 6.

Report of the Committee on Orientation—Reference Committee No. 3

Report of the Committee on Health Careers—Reference Committee No. 3

Report of the Committee on Community and Rural Health—Reference Committee No. 4

Report of the Committee on Air and Water Pollution—Reference Committee No. 4

Report of the Cults Committee—Reference Committee No. 3

Report of the Senior Day Committee—Reference Committee No. 4

Report of the Committee on School Health, Physical Education and Medical Aspects of Sports—Reference Committee No. 4

Report of the Advisory Committee to Woman's Auxiliary—Reference Committee No. 1

Report of the Coordinating Commission on Governmental Medical Services—Reference Committee No. 5

Report of the Technical Advisory Committee on Physician Services (Title XIX)—Reference Committee No. 5

Report of the Advisory Committee on Title XVIII (Social Security Act)—Reference Committee No. 5

Report of the Claims and Utilization Review Committee—Reference Committee No. 5

Report of the Committee on Appalachian and OEO Programs—Reference Committee No. 5

Report of the Committee on Plans and Development—Reference Committee No. 6

New Business

New Business was presented to the House by the Speaker and referred to reference committees indicated as follows:

(A) Resolution from Allen County Medical Society relating to the Kentucky Medical Assistance Program—Reference Committee No. 5

(B) Resolution of Campbell-Kenton County Medical Society also pertaining to the Kentucky Medical Assistance Program—Reference Committee No. 5

(C) Resolution of Fayette County Medical Society pertaining to the Report of the Surgeon General's Advisory Committee on Smoking and Health—Reference Committee No. 4

(D) Resolution of Campbell-Kenton County Medical Society on the subject of Peer Review—Reference Committee No. 5

(E) Resolution of Campbell-Kenton County Medical Society concerning Compensation for Peer Review Activity—Reference Committee No. 5

(F) Resolution of Campbell-Kenton County Medical Society relating to Foreign Graduate Licensure—Reference Committee No. 2

(G) Resolution from Richard B. McElvein, M.D., Fayette County, on the subject of Amphetamines—Reference Committee No. 4

(H) Resolution from Warren, Edmonson and Butler Counties relating to Blue Shield Claim Forms—Reference Committee No. 4

(I) Resolution of Jefferson County Medical Society concerning Compensation for KMA President—Reference Committee No. 1

(J) Resolution of Jefferson County Medical Society pertaining to Approval of Family Planning—Reference Committee No. 4

(K) Resolution of Jefferson County Medical Society on the subject of Medicaid—Reference Committee No. 5

(L) Resolution of Jefferson County Medical Society on Medicare—Reference Committee No. 5

(M) Resolution of Jefferson County Medical Society relating to Departments of General Practice—Reference Committee No. 2

(N) Resolution of Hardin County Medical Society pertaining to Election of Officers—Reference Committee No. 6

Vice-Speaker Cooper announced the meeting places for the nominating committees for general officers and the five trustee districts electing trustees and alternates this year. Doctor Cooper stated that the Nominating Committee would report immediately following the close of the first scientific session on Tuesday morning at the Convention Center, as well as at the second meeting of the House on Wednesday. In accord with the Bylaws, nominations may be made from the floor on Wednesday without discussion or comment. In completing his announcements, Doctor Cooper reminded the reference committee chairman of their noon luncheon. The fact was emphasized that reference committee reports would be made available to the House members at 4:00 p.m., Wednesday, at the entrance of the Terrace Room.

The first session of the House of Delegates was adjourned at 11:20 a.m.

Second Session

Speaker Greathouse called the second session of the House of Delegates to order on September 23, at 7:25 p.m., and the invocation was given by Donald Chatham, M.D., Shelbyville. Doctor Kissinger reported that a quorum was present.

William W. Hall, M.D., Owensboro, Chairman of the Board of Trustees, was then recognized to present the final report of the Board. He read the following resolution, which was passed by the Board at its September 23 meeting, and moved its adoption. The motion was seconded and carried:

WHEREAS, the 1970 KMA Annual Meeting has made a substantial contribution in the field of continuing medical education and has been well received, and

WHEREAS, many individuals, organizations and agencies including guests, and state essayists, scientific and technical exhibitors, newspapers, radio and television stations, hotels, and the Convention Center, have contributed to its success, therefore be it

RESOLVED: that this House of Delegates go on record as expressing its deepest appreciation to all individuals and organizations who have had a part in the development and implementation of the 1970 Annual Meeting.

Following this action, Doctor Scheen was called to the podium, and he gave special recognition to the representatives of the surrounding state medical associations who attended KMA's annual session. These were: T. L. Fruin, M.D., Chicago, President, Illinois State Medical Society; Lowell H. Steen, M.D., Indianapolis, President, Indiana State Medical Association; Oscar W. Clark, M.D., Columbus, Councilor of the Ninth District, Ohio State Medical Association; Tom E. Nesbitt, M.D., Nashville, President, Tennessee Medical Association; George R. Callender, Jr., M.D., Charleston, President, West Virginia Medical Association; and Joseph L. Fisher, M.D., Jefferson City, President, Missouri State Medical Association.

The Vice-Speaker said that the reports of the reference committees would now be read.

REFERENCE COMMITTEE NO. 1*

Harold L. Bushey, M.D.,
Barbourville, Chairman

Reference Committee No. 1 considered the following reports:

1. Report of the President

Paragraphs 11 and 12 on Page 3 referred to Reference Committee No. 6

2. Report of the President, Woman's Auxiliary to KMA
3. Report of the President-Elect
4. Report of the Speaker of the House
5. Report of the Chairman, Board of Trustees

Comprehensive Health Planning Committee Report referred to Reference Committee No. 6

Finance Committee Report referred to Reference Committee No. 6.

Occupational Pulmonary Disease Committee Report referred to Reference Committee No. 3

Emergency Medical Care Planning Committee Report referred to Reference Committee No. 2

Ad Hoc Chiropractic Committee Report referred to Reference Committee No. 3

6. Report of the Secretary
7. Report of the Editor
8. Report of the Treasurer
9. Report of the Delegates to AMA
10. Report of the Executive Director
38. Report of the Advisory Committee to the Woman's Auxiliary

Resolution I—Compensation for KMA President (Jefferson County)

Report of the President

Many years ago, Wilfred Peterson said, "Sooner or later a man, if he is wise, discovers that life is a mixture of good days and bad, victory and defeat, give and take." This past year revealed good days and bad, victory and defeat, give and take. In this final report to you as President of The Kentucky Medical

**In order to make the Digest of Proceedings of the second meeting of the House of Delegates more understandable and because it will occupy less space in The Journal, the KMA Board of Trustees passed the following motion several years ago: "that if no dissenting action on the committee's recommendations is made either by the committee or the KMA Board of Trustees, only the reference committee action on the report be printed in The Journal."*

Association, it is pleasing to tell you that good days have overshadowed the bad during this past year. I am extremely grateful and very proud to have had the opportunity to serve you.

It has given me an insight into the day-to-day activities of organized medicine. It has afforded greater opportunity to work with our Board of Trustees, committee members, and with many of you. It is my sincere belief that this organization is being served by some of the most dedicated physicians in America. For this, you have my lasting gratitude.

Since you are here today to conduct the many and varied affairs of this organization, I want to get very quickly into my final report as President. This is a report to you of selected activities during my tenure. It covers goals to achieve in the future, and a few thoughts I would like to share with you. First, many activities occurred during the year. It is not possible to touch on all of them at length. I do want to set out for you some of the regions of accomplishment of our Association during 1969-1970. These are not in any particular order of importance. It is presented for us to briefly think together about the many, many fields of endeavor which our Association touches in one year.

Let me list for your consideration, some of these activities. Peer Review came of age in Kentucky in 1970. Concentrated effort places us far ahead of most other states. The hard-working Peer Review Committee has functioned almost on a daily basis. Giant strides have been taken in a field that becomes increasingly more important each day. Become activists to keep the right given us at the time of Magna Charta that the control of a profession rests with its own peers. To do otherwise permits the bureaucrats to push us into serfdom.

Much time was spent this year studying, talking, and thinking about the "Physician's Assistant." Our 1970 Interim Meeting and other meetings emphasized allied health manpower. KMA has a firm footing on which to base its future activities in this vital work. No allied personnel should be added unless there is a need. If need is established, a demand for the proper training follows. Much work needs to be done. Much appreciation is due to many members of KMA and the Auxiliary.

A very important, though possibly little known event, took place in Kentucky this year with the formation of our first multi-county society — Pennyrile. With the government continuing to encroach further and further into the practice of medicine, there is a need to show our strength by forming multi-county medical societies. A number of physicians have an opportunity to be effectively heard at every level concerning the many matters which are such an integral part of our lives. It permits more opportunity for educational endeavor and just plain getting to know each other better. This type of development is one of deep and lasting significance to KMA and to the practice of medicine in Kentucky.

Our Rural Kentucky Medical Scholarship Program reached a new peak this year. By 1970 over one million dollars has been loaned to deserving students who are or will practice in the rural parts of Kentucky. We now have 161 loan recipients in over 85 Kentucky counties. The presence of these physicians is vital for adequate medical services in many of these counties. Some counties today would not have a single physician without this fine scholarship program. This subject will be mentioned further in my recommendations.

1969-70 was a legislative year in Kentucky. Often times, those of you who are not intimately involved with this phase of our activity are not aware of the many hours of work given by the Committee on Legislative Activity. Numerous legislative programs sponsored by KMA were passed by the General Assembly. It was a busy and productive year by the Legislature in health and medicine. A record 138 bills introduced in those categories required constant scrutiny and study by KMA. A "Uniform Anatomical Gift Act," an act to allow physicians to treat minors for venereal disease without parental consent, and a bill merging the TB Hospital Commission and the TB Control Section of the State Board of Health are a few of the many bills improving health care in Kentucky.

KMA sponsored legislation to improve the educational standards of all those engaged in the practice of the healing arts in Kentucky. In spite of the Legislature's final lack of action, all legislators are more aware of KMA's *positive* stand for better health care of all Kentuckians. We must continue to inform our fellow physicians, the legislators, and the public that medical quackery is a health hazard as well as a large economic loss. Please help us to introduce good legislation in 1972. The affairs of medicine will remain securely locked in the hands of physicians only if they give enthusiastically of their time, resources, and energy for good citizenship. To do otherwise is abandoning the control of our profession to bureaucrats who are paid by our taxes for their continuous and incessant activities to attain dictatorial policy over us without our consent.

The issue of National Health Insurance is before us. While Medicare is working reasonably well, it has been projected that in the next 25 years there would be a 236 billion dollar deficit in hospital-related benefits alone. Medicaid is in extreme difficulty. The Government cannot handle what it has now. Even the liberal Chet Huntley said in a Life Magazine article, "In 1937-38 I thought the Government was the answer to all our problems. But The Federal Government I have concluded is an insufferable jungle of self-serving bureaucracy." It is obvious that an all inclusive Government take-over would aggravate the problem with no guarantee for improvement. It would certainly not decrease the cost. Money alone cannot solve the health problems anyway. Our Country must learn from previous mistakes and not rush into a totally new health insurance system. Medical progress is at an all time high. Why then try NHI? KMA is responding. AMA is taking positive action. The AMA MediCredit Plan would get the job done at a cost of only 10.2 billion dollars. It is voluntary; Medicare is undisturbed.

Blue Shield and commercial insurance companies

should be utilized more—not obliterated by Government. They have experience, expertise, and desire. The success of our usual and customary program demonstrates the result of a well-planned program and good communications. What has the Government spent in the Medicaid and Medicare Programs on duplicate costs of auditing and accounting alone? Duplicating is expensive.

Physicians must be deeply involved in any medical programs. Governmental officials should learn it well before they are further hamstrung in their own bureaucratic red tape. Physicians must be treated fairly. Their presence at the decision-making table is the only way to assure people of access to medical services. Too, it must be realized that good health requires self-responsibility and action on the part of each person as well as availability of medical services.

These are a few of the wide variety of activities in which we have been involved during 1970. The reports of our officers and committees visualize the work involved. As you must realize, this continued broadening of our activities creates ever greater demands on the KMA staff and particularly on the man who heads the staff. Bob Cox has been my good right arm. He continues to give us superior staff support. My gratefulness is extended to all the staff members, who made my task much easier.

Every man who is privileged to serve this organization as its President, sees many regions wherein he feels the Association could and should be more involved than it is today. In this final report to you, some of these are set forth for your consideration.

There is much talk about "image." Certainly it is an overworked word. However, those of us who have had an opportunity to serve organized medicine know that our collective image could stand improvement. It is for this reason that a recommendation is made to you, that KMA mount a continuing and active public relations program in the year and years ahead. More activity is needed than we have had in the past. We need to look long and hard at the outside organizations which have made proposals to KMA. KMA needs to create a more effective public relations program within our own staff and organization. It is imperative that this be done if our deep concern about the health and health care is projected to all the people of this Commonwealth. Think hard about this.

Continuing Medical Education is demanding, deserving and an essential element to us. More avenues of opportunity are open, such as our Educational Television Committee. The time is now for the profession to give more aid to its practitioners to practice good medicine.

Peer Review has come of age in Kentucky. It is further recommended to you that increased emphasis be placed on Peer Review in the days ahead. A constant effort must be made to assure quality of our own profession in the most advantageous manner possible. There are forces outside medicine who want to tell us how to practice good medicine. For this reason, it is stressed earnestly that Peer Review become an ever increasingly, important part of our activity within KMA. Peer Review is our responsibility. Today it is our privilege. Let us not lose that privilege. The communications media and others are trying to degrade the Medical profession. It is not possible to understand. Society should build on what it has and profit from the mistakes of history. Don't destroy what you have. Practicing physicians are responsible for the practice of medicine.

I have been very intrigued by the use of foundations in medicine. Our best chance for growth and strength is through our Organization and perhaps the foundation approach. Physicians are changing the delivery of health care. All plans initiated depend on the dedication and drive of physicians. Our professional organizational structure needs to be aware and participate in many different methods of delivery of health care in the seventies.

The phrase, "United We Stand," is very meaningful to us in medicine today. If we do not stand united, we certainly shall fall. I would also ask that you look long and hard at the idea of uniting all specialties "under one umbrella" for strength and for administrative purposes, to increase efficiency and economy of operation. It is a part of the united front needed in medicine today. Our Plans and Development Committee is studying this possibility right now. As this Committee becomes our focal point of planning, it does not propose to abandon traditional and proved practices. It did study our resources and programs. It projects long range objectives. Join me to study the actions which may be suggested to you in the years ahead.

One recommendation is to study the possibility that the Rural Kentucky Medical Scholarship Program be aimed more exclusively for those who will practice family medicine. There is a critical need of family physicians in rural Kentucky, where one-third of our physicians are taking care of the health needs of two-thirds of our population. The Scholarship Program has proved one of the most effective methods of helping to improve the program of family practice in Kentucky. You consider this idea. The Scholarship Program could be further expanded if more voluntary contributions are made to it.

Gentlemen, nearing the end of my term of office as your President, I would be most remiss in my duty unless I recommended your serious, thoughtful consideration of the proposed dues increase which has been presented to you by the Ad Hoc Committee on Finance. This top-drawer committee headed by Doctor Henry B. Asman has assembled the information for you.

Our continued involvement in Governmental Relations, Peer Review, Health Manpower, Continued Medical Education, Rural Scholarship Program, Public Affairs, and other fields of medical administration has stretched our budget to the breaking point. Further, the last major dues increase was in 1964. You know what inflation for six years has done to our dollars for general operation and administrative expenses. The cost of living is up 25%. Just to stay even, which is not good enough, demands more money. If KMA is to progress, to grow, to meet the

continuing demands of the public, the Government and our profession, finances must be increased to operate with enough reserve. After serious and profound consideration of this proposal the needed action is obvious if the Association is to properly represent you.

One could talk a long time about everything from ecology to inflation. Too much business lies ahead for that. You have my deep and sincere appreciation for affording me the opportunity to serve as President of the Kentucky Medical Association. I shall continue an unfailing interest and devotion to the private practice of medicine and to this fine organization. You are urged to take a deep and abiding interest in the activities in KMA so that you may better serve whenever you are called upon. You have much more to offer than your dues . . . Your participation and your faith in your hard-working colleagues. We physicians are most fortunate to live such busy, useful lives.

I read somewhere, "when one door closes, another door opens; But we often look so long and so regretfully upon the closed door that we do not see the one which has opened for us." I am convinced of the urgency of a dues increase to meet the financial requirements of an effective program for KMA. Let us as physicians never look too long at the closed door; let us look ahead so that we may better serve our patients, our profession, our organization and our Country.

We are not perfect. There are problems. Yet we in KMA are blessed with the talent to solve those problems.

Gentlemen, I thank you.

Walter L. Cawood, M.D., President

Recommendations, Reference Committee No. 1

The Report of the President was reviewed noting the great deal of time and effort expended for the Association. This committee feels that a wholehearted vote of thanks for a job well done is due him. We would like to take note of the comments concerning the KMA staff as follows: "As you must realize, this continued broadening of our activities creates ever greater demands on the KMA staff and particularly on the man who heads the staff."

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report Of The President Of The Woman's Auxiliary

This year has been one of great challenge and inspiration. The theme of "Get Involved" was chanted throughout the state. The 1,275 Auxiliary members responded well. The President and President-Elect started the year by attending the WA-AMA Fall conference in Chicago. In October, four Auxiliary members attended the Southern Regional Workshop in Dallas. With all our new learning and knowledge we really became "involved" in many activities.

The membership chairman, our First Vice-President, with the cooperation of KMA worked hard to set up an accurate card file of all the physicians in the state. For the first time, this gave the Auxiliary a potential list of Auxiliary members.

Four very interesting and attractive issues of *Blue Grass News* have been published and a page in the *Journal of KMA* entitled "Auxiliary—A Link in the Chain" has carried our monthly message.

Our continued support of AMA-ERF this year has permitted us to return to medical schools $5,559.03.

The Children and Youth Committee has cooperated with the Kentucky Department of Drugs and Narcotics and physicians' wives all over Kentucky have attended a Drug Education Leader Program. The Governor's Conference for Children and Youth found six Auxiliary members participating in the program.

Our message in Community Service has been successfully heard. Governor Nunn invited the Auxiliary to become "involved" in the "Stop Rubella" program. With the approval of KMA we carried this message state-wide. The State Health Department supplied us with movies, pamphlets and a fact sheet. We appeared on radio and TV, attended club and church meetings. PTA's and industrial factories to inform the public of the "Stop Rubella" program. We assisted the County Health Department with the vaccinations on the target date. We are very proud of our work in helping make this a successful program for Kentucky.

At the county level, we have done many things to improve health and health care in the local communities. A boy scout camp has received medical equipment to outfit a first aid station. A Blood Bank is being staffed by Auxiliary members and WA-SAMA. Grade school children have had kidney screening tests. Pre-school children are being given eye screening tests. Newborns are being tested for hearing. A mental hospital has received beauty shop equipment; a boy's farm has received clothing, money and free hair cuts.

Governor Nunn proclaimed March 30 as Doctors' Day and this proclamation was presented to Doctor Cawood at the Interim Meeting. At that time, the KMA officers and trustees of KMA received a red carnation as a token of our friendship and respect.

Four new recipients have been selected for our Health Career Loan Program. This is still our most important public relations project. Every year many worthy Kentucky youths interested in pursuing a health career are turned away because of a lack of funds. Our state rates very low in the number of loans and scholarships available. The Auxiliary program is one of few that is on an interest-free basis to the recipients that graduate. In addition to our state-wide program, many counties have their own local loan and scholarship programs. An application has been made to the J. Graham Brown Foundation applying for $50,000 to help us enlarge and increase the funds for this program.

In November, the Auxiliary started its education of our members so that they could effectively assist KMA in their legislative activities. We attended the Key Man Orientation and we held two orientation

programs of our own. Many women became "involved" when KMA introduced its positive anti-chiropractic legislation. We addressed and stuffed envelopes, made packets of anti-chiropractic literature and via our own pony express system delivered health information packets to the homes of 130 out of the 138 of our electorate. We met with senators and representatives, wrote letters, sent wires and collected over $300 to finance our own legislative campaign. In June of this year 15 Auxiliary members attended the Washington Dinner.

We have donated or pledged in excess of $3,000 to help refurbish the contents of McDowell House. We have served as a clipping service, sending all important local news concerning physicians' activities to KMA for their files.

A Get Acquainted Tea was given at the Interim Meeting and will be given again at the Annual Convention. We hope this effort will interest the wives of the physicians attending the Orientation Program in the activities of the Auxiliary. It is hopeful that your interest and the imagination of your wives will be captured and that you will find our programs important during the year and at convention time.

It was our pleasure to assist KMA and its delegates at the Annual Meeting in Chicago.

In the future of organized medicine and its responsibilities to you, the physician, and to the people of Kentucky, you too have a responsibility and a privilege to serve through organized medicine. The concern will be to preserve health care, its methods of delivery and the doctor-patient relationship. As the wives of physicians this is our great concern. The basic ingredient will be time—doctors' time. Where will it come from in the already too busy day of our husbands? We have this basic ingredient in the Auxiliary. We have the time, but we need you to help us help you.

We need a closer amalgamation with you, KMA: greater responsibility, more duties and more assignments. We want to save your precious hours. We have proven ourselves as capable; we can take your directions. We can carry out your instructions. We are interested.

We need you to help us provide the Auxiliary with a keystone from which to function, at least a part-time coordinator to give continuity and strength to your programs and our projects. Someone functioning with the KMA Headquarters to help the Auxiliary make a more beneficial contribution to you and the profession.

I hope that you, the House of Delegates, will endorse this recommendation to the Board of Trustees that a new structure of leadership be considered for the Auxiliary. This coordinator would learn, and seek out those women that are interested, capable and available, and would have the direct supervision of the Board of Trustees, Executive Director and his staff. This would be a minor expense for major and meaningful accomplishemnts.

Our thanks to you, Mr. Robert Cox, Mr. Gilbert Armstrong, Mr. William Applegate, Mr. Jerry Mahoney, Mrs. Fay Miles, Blue Cross and Blue Shield and the KMA staff for their help and assistance this year. It has been an extreme pleasure for me to serve the women of this state and you, the physicians. I am very proud to say to you, "We have been involved."

Thank you.

Mrs. Hoyt D. Gardner, President
Woman's Auxiliary to the KMA

Recommendations, Reference Committee No. 1

The committee reviewed the excellent Report of the President, Woman's Auxiliary to KMA. We were quite impressed by their continuous activities and appreciate the desire of the President to form a closer coordination with the KMA staff and the Board of Trustees. We recommend that the Board explore the possibility of closer liaison in this regard.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Report of The President-Elect

During the past year your President-Elect has had the privilege of meeting regularly with the Board of Trustees and the Executive Committee, several other committees and serving as ex-officio member of the Blue Shield Board of Directors. Meetings in your behalf have been attended in New York, Washington, Chicago, Denver, San Francisco, and Kansas City. I have consulted often with committee chairmen, your President, past Presidents, and the superb Staff of KMA.

I feel that my exposure to the problems facing medicine throughout the country and especially in our state have been broad and I have arrived at the inescapable conclusion that the organizational structure and the ability of those manning committees of the KMA compare very favorably with any in the country and are far ahead of most.

During the coming year my aim will be to continue to acquaint you with the problems as I have seen them, become more familiar with your impressions and, to the best of my ability, represent you in the places where the impact will be the greatest. Against our wishes, the problems have become almost entirely political and they will remain so for the remainder of most of our lives. Therefore, continued and increased communications, and an increase in organizational expenditures are inevitable if we are to face the dilemma in an effective manner.

As stated, the nature of our problems is political but there are many things we can, and must do on our own, to improve the distribution of medical care, to relieve the scarcity of medical manpower and to better control, within our limits, the costs of medical care. Despite our disclaimer that it is high doctors' fees rather than high hospital costs, that account for the soaring expense of illness—the fact remains that the doctor has a monopoly on hospital admissions and dismissals—no one else can accomplish this feat—therefore, it is certain that peer review must be performed by us or TO us. Some state medical associations have developed outpatient centers in poverty areas; we would be well advised to take

the lead, with the help of our fine medical schools, in doing likewise.

The nature of things in this era is such that a genuine partnership between our medical schools, government and organized medicine is necessary to improve the medical manpower situation—we could suggest methods of organizing programs of training medical assistants, involve ourselves in training programs for nurses and technicians so that their scope and effectiveness could be greater. We could individually and collectively work a little longer and a little more effectively and make a significant contribution toward improving the availability of medical care. In other words, we could streamline and better organize our personal operations to make our individual contributions help fill the breach. The young physician must learn compassion, hard work and sacrifice and self reliance to be effective.

Because we are sure to have some sort of National Health Insurance during our medical lives we must become more political in order that the quality of medicine will not suffer (as it is sure to do, at least in its early stages) and we as individual deliverers of health care will be oppressed to a minimal degree.

I feel secure in the medical expertise possessed by the physicians of Kentucky and the nation. The hope that this will not be diminished by rulings from Washington lies in the effectiveness of your medical organizations in the next few years. The full support of all of you is gravely needed.

Because of the present and imminent gravity of the total medical picture I am especially privileged to have been chosen, by you, to act as your agent for the coming year.

John C. Quertermous, M.D., President-Elect

Recommendations, Reference Committee No. 1

The Report of the President-Elect was reviewed, and the committee wishes him a most successful term of office for the coming year.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Speaker of the House

Again at this time of year, the Speaker and Vice-Speaker must issue a call to all delegates to organize their ideas, present any resolutions they may have from their county medical society or local medical society and attend to their responsibilities as delegates. This responsibility is one which must not be taken lightly by each delegate. You must remember that you represent the medical group and members in your area in regard to rules and regulations governing the activities of your State Society.

Parliamentary procedures governing the House of Delegates this year will be unchanged. Reports of all committees will be presented on Monday morning, September 21, at the first session. Each report will be appropriately numbered and, after its presentation, will be referred by the Speaker to the appropriate Reference Committee. Following this, new business and resolutions which have been submitted at least a week in advance of the meeting to the KMA office will be introduced. These resolutions will be assigned a letter and referred to the appropriate reference committee. Reference committees will meet at 2:00 p.m. on Monday. Again, there will be six reference committees considering the various reports. These committees will stay in session until 3:00 p.m. or continue until everyone has been heard. Following these sessions, they will prepare a report to present to the second session of the House of Delegates. Each delegate will have a copy of all reference committee reports at the second session by no later than 4:30 p.m. on Wednesday. Each member of each reference committee should thoroughly review the report and assist the chairman in preparing same and must duly sign said report prior to its final submission to the House of Delegates.

Any motion longer than twenty to twenty-five words must be reduced to writing, preferably typewritten with a copy handed to the Speaker.

Again, our format for printing the reports to the House of Delegates will be a booklet form and, therefore, we feel easier to locate and in the end will result in a less bulky House of Delegates package. We had several favorable comments about this method last year, and we hope it will continue to be of assistance to the delegates in reviewing and organizing their work.

On behalf of Doctor Cooper and myself, as Speaker and Vice-Speaker respectively, we have enjoyed participating and serving the delegates group and the State Medical Association during this past year.

Richard F. Greathouse, M.D., Speaker

Carl Cooper, Jr., M.D., Vice-Speaker

Recommendations, Reference Committee No. 1

The Report of the Speaker of the House was considered by the committee, and we wish to commend the Speaker and Vice-Speaker for their continued efforts in conducting the business of the House in the appropriate manner.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Chairman, Board Of Trustees

It is customary for the Chairman of your Board of Trustees to attempt to report to you in summary form the activities of your Board during the past Associational year. KMA members have the opportunity to see the complete minutes of the Board which are available in the Headquarters Office. As you might expect, your Board members face and accomplish more work each year and the complete minutes are quite voluminous.

The Board has met seven times during the Associational year, including those meetings during the annual session, and their dedication to the profession has been demonstrated by their untiring efforts and record of accomplishments. Hundreds of physician hours have been expended by these Board members who have so unselfishly served medicine in Kentucky during this past year.

Your chairman is most grateful to these Board members for their time, performance, cooperation, and willingness to assume the responsibility of helping guide the Association during his year as chairman.

First Meeting, September 25, 1969

S. R. Scheen, M.D., serving as temporary chairman, opened the meeting and recognized the new trustees who were: John S. Llewellyn, M.D., Louisville, 5th District and Paul J. Parks, M.D., Bowling Green, 6th District. Re-elected to their respective positions were Keith P. Smith, M.D., Corbin, Treasurer; Richard F. Greathouse, M.D., Louisville, Speaker of the House; Carl Cooper, M.D., Bedford, Vice-Speaker of the House; Lee C. Hess, M.D., Florence, 8th District Trustee; E. C. Seeley, M.D., London, 15th District Trustee; and Douglas H. Jenkins, M.D., Richmond, 11th District Trustee. He then introduced the new Vice-President, David Hull, M.D., Lexington.

The Executive Committee was formed when Doctor Hess and Doctor Llewellyn were elected to serve from the Board with the president, president-elect, vice-president, chairman and vice-chairman of the Board, and the secretary. The Board then elected personnel for membership on the KMA Committees for the 1969-1970 Associational year.

A discussion was held concerning medicare claims following which the new President, Walter Cawood, M.D., made brief remarks prior to the adjournment of the meeting.

Second Meeting, December 11, 1969

The second meeting of the Board of Trustees was a regular session held at the KMA Headquarters Building on December 11, 1969. Members of the Board expressed their sympathy upon learning of the death of Rex Hayes, M.D., Glasgow, a past vice-president of KMA, and past chairman of the Board.

Accepted for information were the President's Report, Headquarters Office Report and Report of Delegates to AMA. A special report was presented concerning the good results of Kentucky physicians at the 1969 AMA Clinical meeting in Denver relating to KMA's promotion of Doctor Robert Long's candidacy for AMA President.

One of the more lengthy items of discussion related to peer review and the recommendations of KMA's Claims and Utilization Review Committee. The mechanism for the operation of reviewing claims at the county and state level was approved and the state committee was expanded by receiving permission to utilize special consultants to be appointed by the Board. It was announced that a part of the 1970 Interim Meeting Program would be on peer review to assist the county societies and advise them of Kentucky's guidelines.

Numerous legislative matters were considered since the Kentucky General Assembly would be in session within a couple of weeks. Specific action was taken on matters concerning the restructuring of the State Board of Health, Medical Licensure, and licensing of interns.

Inquiries had been received concerning the "physician assistant" and other new paramedical categories. A presentation was made on this subject by Joseph Hamburg, M.D., Chairman of KMA's Health Careers Committee, at the request of the Board Chairman. The Health Careers Committee was expanded in size, and its duties broadened to "evaluate, assist and bring before the Board any paramedical program that is proposed in this state, and recommend action to the Board. . . ." It was also reported that the physician's assistant will be a subject of panel discussion for the Interim Meeting.

The Chairman of the Legislative Committee for National Affairs, Hoyt Gardner, M.D., announced that the U.S. Senate had just taken favorable action concerning professional corporations, suggested KMA develop a definitive tobacco statement for presentation to the AMA, and reported that the KMA Annual Congressional Dinner in Washington, D.C. would be held on May 26.

A discussion concerning Kentucky's medical schools followed with a recommendation being made that the Legislative Committee consider new concepts for the medical schools in service to the state and in sources of financial assistance.

George Brockman, M.D., Chairman of KMA's Comprehensive Health Planning Committee was in attendance to update the members of the Board concerning his study of tuberculosis in Kentucky. Noting certain portions of his committee's report had not been implemented, it was agreed a letter would be written requesting such action.

A lengthy discussion was also held on the subject of optometry and KMA reaffirmed its position on legislation expected to be introduced into the Kentucky General Assembly relating to optometry.

Other action by the Board included the appointment of a special medicine and religion committee for the purpose of establishing seminars this year, and the appointment of a KMA representative to a state Food, Nutrition and Health Study Committee.

Membership was authorized in the Woman's Auxiliary to the Student American Medical Association, and student member dues in the KMA were waived for the 1969-70 Associational year. It was reported that the active membership of KMA had reached an all-time high of 2,411 members.

Third Meeting, April 8, 1970

The third meeting of the Board of Trustees was held on April 8, 1970, in conjunction with the KMA Interim Meeting in Gilbertsville. The meeting opened with a number of reports, including the report of the President, Walter L. Cawood, M.D., who commented on the recent session of the Kentucky General Assembly. Budget Committee Chairman, Ballard W. Cassady, M.D., presented the 1970-71 proposed Fiscal Year budget which was adopted.

The report of the Ad Hoc Committee on Finance was presented by Henry B. Asman, M.D., Chairman. The report, calling for the KMA House of Delegates to consider a dues increase at the 1970 KMA meeting, was adopted by the Board.

J. Thomas Giannini, M.D., summarized the activities relating to the campaign of Robert C. Long, M.D., for President-Elect of AMA and urged continued support of all members for Doctor Long's candidacy.

The Chairman for State Affairs of the KMA Committee on Legislative Activities, Fred C. Rainey, M.D., reported at length on the activities of the 1970 Kentucky General Assembly. He pointed out several changes which had taken place due to the implementation of a new committee system, and noted there were nearly 1,400 Bills introduced during the Session of which 10% were medically oriented.

Nominations were confirmed for submission to the Governor for membership on the Governor's Advisory Council for Medical Assistance, the Hospital Licensure Council, and the Board of Nursing Education and Registration.

Considerable discussion was held concerning the activities of the Plans and Development Committee. Thornton E. Bryan, M.D., Chairman, reported the committee had a lengthy and informative session which covered many matters of importance and presented to the Board eight recommendations set forth by his committee. These recommendations included changes in such areas as the Orientation Program, KMA Senior Day Program, urging *The KMA Journal* to publish articles on liability insurance, reaffirmation of KMA opposition to "screening panels," and a proposal that KMA establish a Committee on Medical Economics.

Marvin Bowers, M.D., Chairman of the Claims and Utilization Review Committee, presented a number of recommendations concerning his committee's activities. More detailed recommendations are to be brought back to the Board regarding the changes, membership and responsibility of a new peer review segment of Claims and Utilization Review.

The Commissioner of Health, Russell Teague, M.D., spoke of the great number of claims filed

with Workmen's Compensation regarding Coal Workers Pneumoconiosis. This matter is now under study in the Department of Health and assistance from KMA and the private sector of medicine was solicited. It was agreed to refer this subject to the Ad Hoc Committee to Study Occupational Pulmonary Disease which would have the expertise to deal with the problems set forth by Doctor Teague.

The Board heard and adopted proposed recommendations of the Executive Committee regarding changes in the KMA Orientation Program. A change in KMA Bylaws to reflect an additional year of orientation opportunities will be voted upon by the House of Delegates at the 1970 Annual Meeting.

William W. Hall, M.D., read a report on the "Mental Health Care for the Poor" Conference held in Chicago in March, 1970. KMA was represented at this meeting by John W. Baird, M.D., Chairman of KMA's Committee on Community and Rural Health. The report was accepted for information.

AMA Trustee, Robert C. Long, M.D., reported on current activities and programs of the AMA. He also thanked the Board members for their support of his candidacy for President-Elect of AMA. Following this, a brief report on the AMA Conference on "Mental Health Care for the Poor" was presented by the chairman.

Doctor Hall reviewed the minutes of the March 26 Executive Committee meeting, and emphasized the section dealing with a Medicaid Participating Physician form which has been proposed by the Kentucky Department of Health. Several objections which KMA has to the form were pointed out to the Board during the discussion. Legal Counsel and Thomson R. Bryant, Jr., M.D., Chairman of the Physicians Advisory Committee on Title XIX, participated in the discussion and pointed out that a physician could sign the form in its present composition; however, it was not to be construed whatsoever as an endorsement by KMA. The Commissioner of Health stated that no such form or cover letter would be distributed until it had been cleared with the Physicians' Technical Advisory Committee.

The Medicine and Religion Representative to AMA, J. Campbell Cantrill, M.D., reported on the activities of the AMA Committtee and requested some changes relating to KMA's Committee on which action was delayed pending more study.

George F. Brockman, M.D., reported on activities of the Comprehensive Health Planning Committee and spoke briefly concerning legislation regarding a new TB Control Statute which was passed during the 1970 General Assembly.

A resolution concerning "Physician's Assistant" programs was passed and a request was made that the Board endorse a specific coronary care training program which is being used in hospitals in surrounding states. No action was taken pending further study.

The meeting closed with Doctor Hall reminding the Board of Trustees of the Washington Dinner, scheduled for June 1-2, 1970, and requesting staff to investigate locations for the 1971 Interim Meeting.

Fourth Meeting, August 6, 1970

Annually, the August meeting of the Board is held primarily to review the reports of all KMA committees. The action of the Board is noted on each report prior to its submission to the House of Delegates. Some committee chairmen were in attendance to present their reports personally, and all trustees had been assigned specific reports to study thoroughly prior to the Board meeting.

The President, Secretary and Senior Delegate to the AMA presented routine reports to the Board. Specific action was taken on recommendations made by the Advisory Committee to Blue Shield, Health Careers, Coronary Care Units and Plans and Development Committees. It was agreed to invite the Advisory Committee to Blue Shield and Claims and Utilization Review Committee Chairmen to the September 20 Board meeting to discuss the Usual, Customary and Reasonable Program in more detail and to request Blue Shield staff representation.

The Board then (1) set September 23-25 as Annual Meeting dates for 1975, (2) confirmed that the KMA Conference on Medical Education would be held January 23-24, 1971, at Park Mammoth, (3) agreed to hold the 1971 Interim Meeting in Cave City at the Holiday Inn on April 14-15, and (4) decided upon its Judicial Council nomination to present to the House of Delegates.

After receiving a KEMPAC recommendation requesting KMA to bill all members for dues direct, a Committee on Electronic Data Processing was appointed to make initial studies and report back to the Board at an early date. A discussion was also held on the dissemination of information to the membership relating to the proposed KMA dues increase.

The Board then elected its editors for *The KMA Journal* for the following two years which were Walter I. Hume, Jr., M.D., Editor; Henry B. Asman, M.D., Associate Editor; Sam A. Overstreet, M.D., Assistant Editor; Charles C. Smith, M.D., Scientific Editor; and Eugene Conner, M.D., Book Review Editor.

Four Board meetings were set for the KMA Annual Session, and this meeting adjourned after being in session in excess of seven hours.

In keeping with the policy of assuming more responsibility and meeting as often as is necessary to conduct the business of the Association, the Executive Committee had some lengthy meetings this past year. The Executive Committee business transactions are reported to the Board and matters of major importance are presented to the Board with a recommendation of the Executive Committee.

The Board was privileged to have had seven Ad Hoc Committees serving under its jurisdiction this year. These committees were: Comprehensive Health Planning, George F. Brockman, M.D., Chairman; Finance, Henry B. Asman, M.D., Chairman; Kentucky Medical Association-Kentucky Nurses Association, A. Evan Overstreet, M.D., Chairman; Occupational Pulmonary Disease, John Eckerle, M.D., Chairman; Emergency Medical Care Planning, William T. Rumage, Jr., M.D., Chairman; Medicine and Religion, J. Campbell Cantrill, M.D., Chairman, and Ad Hoc Chiropractic Committee, David B. Stevens, M.D., Chairman.

The KMA-KNA Joint Advisory Committee held its single meeting this year on May 14, 1970, at the Headquarters Office of the Kentucky Nurses Association in Louisville and reported to us as follows:

"A lengthy discussion was held concerning the proposed KMA-KNA joint statements of policy which were offered by this body to the KMA House of Delegates last year for consideration and which were subsequently disapproved. It was noted that the Reference Committee, who last year, reviewed our report containing the statements had felt them to be too broad for use as policy and had recommended that guidelines first be established. After further deliberation, the KMA-KNA Joint Advisory Committee agreed to work toward the development of such guidelines. Hopefully these guidelines, when finalized, can be used by institutions as dictated by their particular needs, with the institution determining the capabilities of those personnel performing various duties."

"A great part of our discussion was in regard to the concept of utilizing nursing personnel in the expanded role of a physician's assistant or clinical associate. There was some concern expressed as to what effect this concept would have on the already present shortage of nurses and what the role of this individual would be under existing medical licensure laws."

"Representatives of our group were pleased to

attend one meeting of the KMA Health Careers Committee to become more familiar with proposed training programs for new allied health workers which directly involve the nursing profession. Representatives of our group have also been invited to attend future meetings of that committee when their topics of discussion concern items of this nature."

"We believe that much can be realized from the KMA-KNA Joint Advisory Committee, the purpose of which is to discuss and ventilate ideas and problems which may affect the nursing profession, medical profession and health care in general. The members of both committees are to be recognized for their interest and cooperation."

Our KMA Ad Hoc Committee on Medicine and Religion reported "that although they did not meet until late in the summer, on August 5, your committee chairman has had the pleasure of working at the national level with the AMA Committee on Medicine and Religion. The functions of the AMA Committee have been expanded to assure other than pastoral-medical relationship of the dying patient. It was working with clergymen throughout the world to determine exactly where, morally, physically and ethically life ends."

At the state level, the committee has recommended that it be expanded to include physicians closely related to each medical school and physicians having direct contact with the six theological seminaries in Kentucky to carry out the AMA programs at the state level. In addition, the committee wishes to increase liaison with the various specialty and allied health groups to implement this program.

The committee desires to create a close relationship between physicians and theologians and hopes to accomplish this by presenting a number of medicine and religion seminars throughout the state next year.

Your chairman had the privilege of attending a meeting of the AMA Medicine and Religion Committee of which he is a member on February 19 in Chicago and also attended a regional meeting in March of this year in that same city. While attending the AMA Annual Convention in June, your chairman represented the Association at the Annual Medicine and Religion Panel on Sunday evening, June 21, on an indepth discussion centered on "Crises a Time for Counseling."

Each ad hoc committee chairman expressed deep appreciation to their committee members and to staff for their excellent contribution to the various committee activities. A list of all committee members is included in your Delegate's Handbook.

William W. Hall, M.D., Chairman

Recommendations, Reference Committee No. 1

The Report of the Chairman, Board of Trustees, was reviewed with the exception of the sections on the Comprehensive Health Planning Committee Report, Finance Committee Report, Occupational Pulmonary Disease Committee Report, Emergency Medical Care Planning Committee Report and Ad Hoc Chiropractic Committee Report. The report shows the extensive work of the Board throughout the year. We wish to commend the members of the Board for their untiring efforts on the part of our Association.

The Report of the KMA-KNA Joint Advisory Committee and the Report of the KMA Ad Hoc Committee on Medicine and Religion were noted with interest.

The supplementary attachment to Report No. 5, Report of the Chairman of the Board of Trustees, as quoted below, was considered.

"WHEREAS, on June 11, 1959, the American Medical Association adopted a policy on health care costs which stated:

'In an effort to decrease, or at least to prevent an increase, in the over-all cost of health care, study should be given to the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made.'

(Report D of the Board of Trustees, 6/11/59) and

WHEREAS, by both contract and statute payment for many medical services are still so conditioned, and

WHEREAS, there is increasing general concern over health care costs,

BE IT THEREFORE RESOLVED that the American Medical Association press for greater acceptance of the economics and patient convenience of out-of-hospital care."

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Report of the Secretary

It is again time to look back over the year and evaluate and consider those things which have taken place in the last year in the KMA. One simply has to review the reports to the House of Delegates from the numerous committees and from the Board of Trustees to realize how much work has actually been done this year and it seems that each year the work load becomes more and more heavy and broader in its scope. These reports are indicative of the tremendous amount of work which has been done by the members of KMA who serve long and well and without complaint on these committees. It is most gratifying to be associated with so many men who are so dedicated to their work and carry out their duties with thoughtful deliberation and complete fairness.

This year has been another year in which KMA has been extremely busy and again the major problems have been in our effort to assist in the implementation of the various governmental programs, both at the state and national level. As in all relatively new programs, there have been many details to work out requiring much deliberation with all concerned parties. It has been, however, very rewarding in that we have all tried to work together to promote these programs in the best interest of good medical care for the people of the state of Kentucky.

Again, I would like to commend our KMA staff who have done such excellent work throughout the year. It would be impossible to list the numbers of duties required of them to carry out your work at the KMA level. We are indeed fortunate to be blessed with such a good staff who keep things running so smoothly for all of us; and yet, we little realize how much effort they actually put into arranging all of the committee meetings as well as the Annual State Meeting, the Interim Meeting, and others too numerous to mention.

To give you some statistics regarding the number of meetings in which the Association has been involved in the past year, there were 66 KMA committee meetings which lasted 203 hours with 414 KMA members in attendance. This involved 1,316 doctor hours and 61,744 doctor miles traveled. There were 6 KMA Board meetings which lasted a total of 23 hours at which 177 KMA members were in attendance. Seven hundred doctor hours were involved in KMA Board meeting travels and 28,924 miles. The Executive Committee met four times, lasted 33 hours, with 31 KMA members in attendance, 224 doctor hours, and 8,186 doctor miles traveled. This means that there were almost 100,000 miles traveled in attending KMA committee meetings, KMA Board meetings and Executive Committee meetings this year. These are rather impressive figures.

Another point that I would like to mention is that

there were 20 KMA representatives at 15 out-of-state meetings. This would be a total of 148 days attending out-of-state meetings, or if we look at it another way, this would be a KMA representative at an out-of-state meeting approximately every other day through this past year. During these out-of-state meetings, there were 58,706 miles traveled. Again, these statistics, I think, indicate the amount of work which has gone into the Association this year.

I would again like to thank all of those who have been helpful to me in this past year with the secretarial job. I would like also to remind you gentlemen who are the elected delegates from your areas that it is your job to attend the meetings and to report the actions of the House to your particular society. Yours is an extremely important job. With more and more participation of KMA in numerous projects, it is all more important for us to maintain our contacts with our component members of the society, to carry out their wishes, and to attempt to aid in any way we can all the members of this society through you, the elected delegate. I would like to close this report with another vote of thanks to our fine KMA staff and another commendation for a job well done for another year.

Randolph Scheen, M.D., Secretary

Recommendations, Reference Committee No. 1

The Report of the Secretary was reviewed with special interest concerning the tremendous amount of doctor miles and doctor hours noted in the functioning of the Kentucky Medical Association.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Editor

The editors of *The Journal* have continued to meet at regular intervals during the year. A surprising amount of material requires attention on the Monday morning agendas.

The Editor is submitting his resignation after four years of being editor and six years as associate editor. The Editor is recommending to the Trustees the appointment of Doctor Walter Hume as editor, Doctor Henry Asman as associate editor, Doctor Sam Overstreet as assistant editor and Doctor Charles Smith as scientific editor. Doctor Eugene Conner will remain as book review editor and Doctor Lewis Dickinson as insurance editor.

The Editor wishes to thank his fellow editors for their excellent work during this past year and also to thank Mrs. Maxey and Mr. Bob Cox for their excellent support and cooperation. Working with *The Journal* over this peroid of time has been a pleasant and interesting experience. It is the opinion of the Editor that *The Journal* continues to serve a worthwhile purpose for Kentucky medicine.

It is to be noted in a recent analysis of the financial status of the Kentucky Medical Association that *The Journal* has a $14,000 deficit for the past year. However, it is to be understood that this does not take into account any subscription dues to *The Journal* from any member of the Association. For example, if a $5.00 subscription figure were arrived at for each member, *The Journal* deficit would then be something in the region of $2,000. It is also to be understood that in the present method of cost accounting that a certain percentage of the operational cost of the KMA office is allocated to *The Journal*.

At the present time preliminary studies are being made to determine methods of reducing the cost of publication of *The Journal*. Recommendations in this regard will be made to the Trustees in the future.

Walter S. Coe, M.D., Editor

Recommendations, Reference Committee No. 1

The Report of the Editor was reviewed. The Editor and his staff are to be complimented on their efforts to publish *The Journal* at the minimum of cost.

We regret that Walter S. Coe, M.D., has resigned as editor and commend him for his efforts in the past. We wish the new editor and his staff all success.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the KMA Treasurer

Enclosed in your House of Delegates envelope you will find a Statement of Financial Condition of the Kentucky Medical Association as of June 30, 1970, a Statement of the Changes in the Fund Balances, and Condensed Statements of Income and Expense of the Current Fund, Reserve Fund, McDowell House and the Postgraduate Medical Education Fund for the year ending June 30, 1970.

The complete report of audit for the fiscal year just ending is available to all members of the Kentucky Medical Association at the KMA Headquarters Office, 3532 Ephraim McDowell Drive, Louisville, Kentucky.

In the event you may have any technical questions relating to this report, a representative of our accounting firm will be present in the reference committee hearing on Monday, September 21.

Keith P. Smith, M.D., Treasurer

Recommendations, Reference Committee No. 1

The Report of the Treasurer was reviewed with the help of a representative of KMA's auditing firm. The financial affairs for the fiscal year ending June 30, 1970, were reviewed in depth. It is obvious that the expenses are catching up with the income and that the reserve is not what is considered adequate.

It is recommended that the Board update the insurance coverage on all KMA properties and assets.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Report of the Delegates To AMA

The AMA Delegates and Alternate Delegates, along with officials of the state medical society, have been in attendance at the two AMA meetings this past year—the first on November 30-December 3, 1969, at Denver, Colorado, and the second on June 23-25, 1970, at Chicago, Illinois.

Clinical Session

The first meeting of the year 1969-70 was held in Denver, Colorado, on November 30, 1969, to December 3, 1969. The House of Delegates was very active in the formation and approval of the Ad Hoc Committee's study of the Modus Operandi of the

Scientific Sessions which had been adopted in 1969 at a convention in New York. The reference committee recommended approval and the House did approve the Ad Hoc Committee's study on the Modus Operandi of the Scientific Sessions. The recommendation regarding a private practice council was considered at length and the House approved an amended version which stated that there should be a Committee on Private Practice as a part of the Council of Medical Services. In response to the necessarily economy-minded House, the AMA-ERF Biomedical Research Institute was recommended to be discontinued because of the lack of funds and the lack of broad support from numerous sources. It was with a great deal of reluctance that the House approved the liaison committee reports which means the institute will be gradually phased out. Considerable discussions were held in regard to medical-legal subjects and attempts were made to better relations between the Bar Association in regard to attempts to change the contingency fee system as well as the statutory limits on damages. This was recommended to the Board to continue to search for a solution in this area as a matter of urgent priority. Numerous other needed reformations in the field of the AMA government agencies and subsidiary liaison agencies were pointed out and numerous requests were made for a better negotiating of understanding between government agencies and practicing physicians and AMA authorities. This was primarily concerning federal statutes and regulations and the AMA's not being consulted in some of the directives put out. It is possible in the foreseeable future that a better understanding will occur and that the AMA will be consulted more on governmental health affairs. Numerous requests and recommendations regarding the use of drugs, narcotics, etc., were presented to the House of Delegates. In the category of drugs it was felt that the FDA has taken upon itself the exposure of and withdrawing of drugs and making substitutes which do not make the criteria set up for other drug concerns. This is a matter which will have to be resolved through the AMA's Committee and Council on Drugs and by governmental agencies. The most important consideration in all probability regarding the Denver meeting was the special session held for Reference Committee I which has to do with the long-range planning and development of AMA. There was a majority report and also a minority report. It became evident through the course of all the discussions that there was a lack of unanimity among the members and that this would require further discussion, study and recommendations before it could be passed on by the entire House. Therefore, it was directed that the report be thoroughly studied and that at the next House of Delegates' meeting recommendations could be presented to the House for approval.

ANNUAL CONVENTION

This is the first uninterrupted annual convention since the 1967 meeting and it was prompted by the AMA Board of Trustees formation of a reference committee to hold a public forum so that dissident groups might express their opinions regarding the AMA's position, action and responsibility in the health care field. This meeting was also the one which KMA presented Dr. Robert C. Long as a candidate for President-Elect of the AMA. Dr. Long was one of four candidates and Dr. Long's race was one sponsored with great enthusiasm by KMA and other allied organizations who were interested in the health fields. Dr. Long survived the first two ballots and was a close second to the ultimate winner who was Dr. Wesley W. Hall of Reno, Nevada.

Dr. Gerald Dorman in his final address to the House made a plea for all members of medicine to give us the best of leadership that we can possibly muster in the health care field and as a means of demonstrating our interest he suggested that we set a specific minimal health standard for all the people of the United States, saying that we must renew our contact with the others of the health care field and re-dedicate ourselves to see that complete health care is given to everyone in the United States. Dr. Walter Bornemeier in his inaugural address cited areas in which improvement of medical care could be rendered in medical education and training; shortening the curriculum for medical school; modernizing or shortening residency programs and having more medical teachers in patient-medical care and reducing to a degree in number medical research institutions and researchers.

The House of Delegates of the AMA in 1969-70 considered a tremendous volume of business which included 61 reports and 140 resolutions and eight memorial or commendary resolutions and 27 special ones, generated by the Himler Committee's Report on Planning and Development of the AMA.

The question of the AMA's positions on abortion generated considerable discussion throughout the meeting and the House of Delegates went on record as approving abortion in the context of its previous position, stating that it should be done by competent physicians, with competent consultation in the hospital and should be done for medically approved conditions which were not in conflict with any state legal medical practice acts.

The consumer forum again prevented the interruption of the House of Delegates meetings. At this meeting those who have any alleged grievances of AMA care, planning or operation were given an opportunity to express themselves. This was reported to the House and the House suggested that possibly the AMA advisory committtee on health care of the American people consider making this a yearly program.

Dues increase: The House of Delegates on recommendation of the reference committee took unto itself the question of increasing dues, which prior to this meeting had been the prerogative of the Board of Trustees. The AMA House of Delegates after hearing testimony did approve a dues increase of $40, making annual AMA dues $110. At the same time the House directed the AMA financial committee and Trustees that in the future any question of dues increase should be given publicity to all state associations to enlist their efforts in order to increase the dues without the trouble which accompanied this dues increase.

The House of Delegates approved numerous recommendations also regarding the re-affirmation of the AMA's basic philosophy of the "promotion of the art and science of medicine and the betterment of public health." They also noted that the AMA had responsibility in attempting to attract the most highly qualified candidates to the field of medicine; recommended that the AMA expand its active role in planning developmental programs for medical care in all of its ramifications and to assist state and county medical societies in the same regard. The AMA reaffirmed its desire to help in all ways the Council on Health Manpower in order to provide medical care for more rural areas and to develop expedient methods to overcome these deficiencies at the present time. The House approved the necessity for physicians' assistants in numerous fields of medicine and directed the appropriate councils to institute programs and to set up guidelines for certification of programs. The AMA endorsed the principle of voluntary lifelong postgraduate study for all physicians in the field of continuing education and reiterated its feeling regarding the state medical association's necessity of designating representatives to deal energetically with all third party agencies and programs and utilizing the concept of usual, customary and reasonable charges as a basis for all considerations.

In the field of education the House approved numerous essentials of residencies for the many specialty groups and recognized the necessity for internships to be approved in the future with a combined residency program as a means of giving the best medical care to all segments of the country.

In the field of professional liability the House approved a Board report stating that insurance protection is essential so that all physicians may continue to provide needed medical care to the public; and it felt that the best way to provide this would be under a program jointly sponsored by the AMA and respective state medical societies in conjunction with a liabiltiy carrier; and the board, at the present time, is seeking with the insurance industry a method of getting professional insurance programs under joint sponsorship so that the states which may elect to participate may be included.

The House also approved all present nursing plans and suggested means of improving and encouraging more candidates to enter nursing to alleviate the nurse shortage throughout the country and methods of providing more nursing help to all hospitals and health care areas.

In the field of drugs the House took important actions concerning many drugs and noted that it approved the position of support, maintenance and enforcement of anti-substitution laws and regulations which some government agencies have suggested.

Hospitals: The House went on record as requesting to JCAH that the committees include where feasible adequate representation from community base hospitals elected by the medical staff.

In other miscellaneous action the House suggested possibly the formation of a subsidiary corporation to engage in publication of medical materials for possible tax benefits. The House adopted a Board proposal undertaking a communications program for 1970's in documentary, educational advertising and other related activities to improve the purpose and understanding and image of the medical profession.

The House again approved and supported the continued efforts by the AMA to inform the medical profession of the value and benefit to be realized from the implementation of adequate Peer Review Programs and directed the Board of Trustees and councils and committees and other appropriate sections of the AMA to give this project the highest priority and emphasize its urgency to component state and county medical societies.

I wish to recognize the excellent help given the delegates and alternate delegates by the officials of the state medical society, KMA staff, representatives of the county medical societies and by numerous members of the KMA who contributed of their time and efforts in order to make our comprehensive report to you. Special recognition is extended to our other two Delegates, George Brockman, M.D., and Charles Rutledge, M.D., and to our three Alternate Delegates, Doctors Charles Bryant, Daryl Harvey and David Stevens.

J. Thomas Giannini, M.D., Senior Delegate

Recommendations, Reference Committee No. 1

The Report of the Delegates to AMA was reviewed. As usual, they functioned in a very efficient manner in behalf of KMA. We take note of Doctor Long's race for the position of President-Elect of AMA and commend the outstanding efforts of those participating in the campaign.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Executive Director

As we approach the end of another Associational year, it is certainly a challenge for me to report to you a summary of the responsibilities and activities of the Headquarters Office. Details of staff activities are interwoven in the various reports contained in this booklet, the publications you receive, the associational meetings you attend and in representing you at most medically-related functions held in the Commonwealth.

Last year I reported my impression of an average day in your Headquarters Office. I believe that "average day" has mushroomed at a greater percentage of increase than any of the inflationary figures I have seen thrown around lately. It reflects, I think, not only the profession's concern for health care but the increased governmental role, public involvement, third-party expansion, a multitude of proposals for innovations in the health care delivery system and the plain fact that more professional people are providing more services for an increasing population.

Since last year, we have seen, for example:

1. More and greater-in-depth committee activity;
2. The Judicial Council increase its meetings by fifty percent; (All meetings of any committee obviously take numerous staff hours for preparation and follow up.)
3. A continuing increase of legislative and government medical matters.
4. Peer Review activity bring new staff responsibilities in meetings, records, correspondence, etc.;
5. Better communications become a personal staff objective, and attempts made to maintain closer liaison with representatives of the communications media;
6. Routine programs such as the Rural Kentucky Medical Scholarship Fund perpetuate increased work loads. The Scholarship Fund surpassed the one million dollar mark in loans this year. With recipients practicing in nearly ninety Kentucky counties and new loans being made annually, maintaining the essential close contacts with our recipients involves a proportionate amount of additional staff time.

This was a legislative year, and we were fortunate to have two men working full time in the 1970 Kentucky General Assembly (a request of the 1968 House of Delegates). Having both the House of Representatives and the Senate covered daily by staff was of great aid to us in fulfilling our required assignments. I am convinced that this decision was a necessary one and that we should continue in this manner. I think it should be noted, however, that the additional legislative and external staff help that was implemented created a greater obligation in the internal administration of the Headquarters Office. Changes were made in staff assignments, but the number of Executive Staff personnel remains unchanged since 1964.

As well as notes and memory could serve us, during the past twelve months staff planning, attendance and implementation was required in over 200 meetings; and, in addition, some 68 staff days were spent representing the Association at out-of-state meetings. These are reported only to demonstrate the activity being accomplished in KMA by the membership which evolves around the Headquarters Office. I thought it might be of interest to see these meetings

listed on a day-to-day basis; but due to the space it would require, I did not include such a listing in this report. However, it will be made available to the members of Reference Committee No. 1 for their information.

If the growth of challenges and accomplishments, responsibilities and opportunities, programs and progress were charted for medical associations, the graph would reflect a trend which, I believe, would make any Wall Street financier envious.

At the same time, I feel we may be in the "market position" where these same challenges—responsibilities—opportunities are about to increase at a greater pace than ever. Legislation is again the cause for some of this. If Medicare should ever get a Part C as is now being proposed, what is to be the medical profession's response through its organizational structure? Many state medical associations and major county medical societies are already into or are taking a serious look at "medical foundations." The AMA Board of Trustees has requested a study on the foundation development, its status, advantages and disadvantages.

A Peer Review Organization (PRO) has been introduced in various forms in Congress. Such an organization, if passed by Congress as proposed, would have state and local structures reviewing in-patient and out-patient claims, utilization and quality of care. The legislation provides that this review authority be lodged wherever possible with medical societies.

Liability Insurance is becoming an increasing problem, and the American Medical Association is establishing a national liability insurance coverage program which is to be available for state medical associations should they desire to participate. Should it become a reality in Kentucky, it would obviously require more Headquarters administrative output.

Other state-medical-association-sponsored programs in the medical economics field are now receiving favorable consideration. Such concepts include special group rates to members for automobile leasing, disability and life insurance, investment and management consultants, etc.

Continuing emphasis is also being directed at allied health personnel—The Physician's Assistant—Continuing Medical Education, more sophisticated PR efforts, and such local proposals as the formation of multi-county medical societies.

Handling such continuing growth in activities and increasing needed services to the membership requires careful study in the utilization of more modern equipment. Savings can be realized by combining some efforts with other state medical associations, and the use of computers by KMA could become an inexpensive reality that could save time and effort for many of our members. It has been a busy year, and it looks as if more is to come.

There are three officers with which the Executive Director has an opportunity to work very closely; the President, Chairman of the Board and Secretary. For their time, understanding and counsel, I am deeply indebted to Doctors Walter Cawood, William Hall and Randolph Scheen. A very deep appreciation is extended to the entire official family of KMA, the officers and members of the Board of Trustees, *The Journal* editors, the committee chairmen and committee members and to the individual members with and for whom we have had the pleasure of working.

I have an inexpressible feeling toward a superb staff, all of whom daily demonstrate not only their ability and desire to surpass what might be expected of them, but a deep respect for their individual assignments and a sincere dedication to perform in the interest of the Association.

Your staff appreciates having the opportunity of serving you. All staff assignments and activities are under constant review to insure maximum effectiveness.

Robert G. Cox, Executive Director

Recommendations, Reference Committee No. 1

The Report of the Executive Director was considered in detail. We have all praise for the Executive Director and his staff for the loyal performance of their duties for the Association. It is noted that the staff has remained unchanged in size since 1964, but additional demands have been placed upon them.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Advisory Committee to the Women's Auxiliary

Under the capable leadership of its President, Mrs. Hoyt D. (Rose) Gardner, and a dedicated group of officers and Board members, the Auxiliary has had a busy and productive year. The task of the Advisory Committee has been an easy one, involving, at most, an occasional informal discussion of programs and plans.

The attention of the House of Delegates and the Board of Trustees is especially directed to the recommendation made in the closing paragraphs of the Report of the President of the Auxiliary. This innovative suggestion deserves careful consideration and study of the mechanisms and financing of a plan whereby the Association could profit by the day-to-day coordination of the efforts of the Auxiliary with those of KMA in the pursuit of our goals.

Henry B. Asman, M.D., Chairman

Recommendations, Reference Committee No. 1

The Report of the Advisory Committee to the Woman's Auxiliary was reviewed, and the Committee noted again the desire for coordination between the Auxiliary and KMA.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Resolution 1

Jefferson County Medical Society

WHEREAS, serving as President of the Kentucky Medical Association is a distinct honor but a tremendously time-consuming office, and

WHEREAS, the Presidency of the Kentucky Medical Association imposes considerable financial sacrifice on the individual so honored, and

WHEREAS, physicians of ability, integrity and

possessing outstanding qualities of leadership are sometimes unable or unwilling to make the necessary sacrifice of time and money required to serve as President of the Kentucky Medical Association, and

WHEREAS, the entire membership of the Kentucky Medical Association urgently needs the best available physician to occupy the office of President of their organization, therefore be it

RESOLVED, that a mechanism be evolved by the Budget Committee of the Kentucky Medical Association which will ease any financial loss from the practice of medicine incurred during the year of his imcumbency by the President of KMA.

Recommendations, Reference Committee No. 1

Resolution I, Compensation for KMA President, introduced by the Jefferson County Medical Society, was discussed in some detail by the committee and past presidents who felt that its implementation is not feasible. We further feel that the new expense compensation plan of the KMA Board of Trustees should be given an adequate trial and recommend that Resolution I not be adopted.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Mr. Speaker, I move the adoption of the report of the Reference Committee No. 1 as a whole.

(Motion was seconded and carried.)

Mr. Speaker, as chairman, I wish to thank all of the members of this committee for their untiring efforts and help in preparing this report.

I would also like to thank Miss Libby Spalding for her excellent help.

REFERENCE COMMITTEE NO. 1
Harold L. Bushey, M.D., Barbourville, Chairman
Winston L. Burke, M.D., Lexington
Frank M. Gaines, Jr., M.D., Louisville
Walter R. Johnson, M.D., Paducah
Glenn F. Baird, M.D., Florence (Absent)

REFERENCE COMMITTEE NO. 2

Faull S. Trover, M.D., Madisonville, Chairman

Reference Committee No. 2 considered the following reports:

14. Report of the Scientific Program Committee
15. Report of the Scientific Exhibits Committee
16. Report of the Committee on Medical Education
17. Report of the Hospital Committee
18. Report of the Committee on Educational Television
19. Report of the Disaster Medical Care Committee
20. Report of the Cancer Coordinating Committee
5. Report of the Chairman, Board of Trustees, Emergency Medical Care Planning Committee Report only

Resolution F—Foreign Graduate Licensure (Campbell-Kenton Counties)

Resolution M—Departments of General Practice (Jefferson County)

Report of the Scientific Program Committee

The charge to the Scientific Program Committee is to plan, promote and implement the scientific sessions held each year in conjunction with the KMA Annual Meeting. To properly carry out this responsibility, it is necessary for the committee to meet to develop its plans nearly a year in advance of the Annual Convention.

In addition, early in the Associational year, your Chairman had the pleasure of meeting with the 16 specialty group presidents to discuss their participation in planning this year's meeting. I am grateful for their approval of the facilities offered for their meetings and for their cooperation in the planning of the overall meeting. The scientific programs of the specialty groups, held in conjunction with our General Sessions, have proven over the years to be valuable to all concerned and provide an outstanding contribution to the continuing education of our members.

Preparation for each year's scientific session includes the review of previous programs in an attempt to select the most popular aspect of those sessions to compliment any new concepts presented. It is the desire of the Scientific Program Committee to present an appealing and educational program that provides maximum benefit to the members of KMA.

This year, we are attempting a blend of individual papers and panel discussions. A popular innovation of last year's meeting, the "Crackerbarrel Session," will again be presented this year, which will permit informal roundtable discussions, on Wednesday afternoon.

We have carried over the policy of selecting themes for portions of the scientific program which are designed to assist in the continuity of the program and afford an opportunity for indepth coverage of the subject. From past experience, it has appeared that the selection of themes has proven to be beneficial and we hope you will again find them to be profitable.

We are pleased to again have the South Central Bell Telephone Company sponsor our message center in the Technical Exhibit Hall and wish to extend our appreciation to them. Each year, this continues to be a growing and valuable service to our association and our members.

Once the plans for the scientific sessions are finalized, your Chairman, committee members, specialty group presidents and KMA staff become involved with countless phone calls, personal contacts and reams of correspondence in promoting and implementing these plans. Your chairman is grateful to all those who assisted in the formation of this program and especially to the members of the committee, program moderators, and specialty group presidents.

Allan M. Lansing, M.D., Chairman

Recommendations, Reference Committee No. 2

The Report of the Scientific Program Committee was studied and this committee certainly should be congratulated on the excellent program that has been arranged. It is recognized that a great deal of work was done in completing this program.

We wish to thank the South Central Bell Telephone Company on behalf of the Kentucky Medical Association for the continued sponsorship of the Message Center.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Committee of Scientific Exhibits

As it is necessary for our committee to meet late in the summer to review all applications for scientific exhibit space at the Annual Meeting, it has become our policy to submit our final report in advance of our meeting to insure that it will be processed and distributed with the other committee reports.

Our meeting is being held this year on July 9, at which time we will carefully review all applications submitted to us and make selections of those to be presented.

We anticipate having approximately twenty scientific exhibits for the 1970 meeting. They are to be in place in the Convention Center by 8:00 a.m. on Tuesday, September 22, and will not be removed until 3:30 p.m. on Thursday, September 24.

Our policy of judging the exhibits is being continued, and the judging team will select the most outstanding exhibits, with the first place award recipient being recognized during the General Sessions at 11:30 a.m. on Wednesday morning.

Special badges and ribbons are used to identify our scientific exhibitors, and they are eager to discuss their exhibit with you. A certificate is awarded each exhibitor in appreciation of his interest in this phase of continuing medical education.

Our committee members desire to take this opportunity to urge all members attending the Annual Meeting to visit the exhibits which will be located in the Convention Center between the technical exhibit hall and the General Sessions. We would like to see more of our members present exhibits, and we urge your consideration of planning toward such a project for next year's meeting.

T. R. Marshall, M.D., Chairman

Recommendations, Reference Committee No. 2

The Report of the Scientific Exhibits Committee was studied and the reference committee wishes to compliment the committee and the exhibitors for their cooperation in making this program a success.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Committee on Medical Education

The Medical Education Committee held two formal meetings this year on November 13, 1969 and April 16, 1970.

One of the responsibilities assigned the committee is to study and make recommendations on matters relating to PL 89-239 (Heart, Cancer and Stroke). The committee noted with interest that the direction of the Regional Medical Programs, as originally set up, has recently changed toward the development and more efficient utilization of medical manpower, particularly those involved in ambulatory (non-institutionalized) care. We also note the similarity of these programs to those of PL 89-749 Comprehensive Health Planning.

The committee particularly discussed the postgraduate medical education phase of the Ohio Valley Regional Medical Program and made a recommendation regarding the establishment of an office of continuing medical education at the University of Louisville School of Medicine.

Your committee members are pleased to assume their responsibility with the American Medical Association Education and Research Foundation. It has been our pleasure to promote tax deductible contributions to this organization which provides loans to medical students and unrestricted grants to medical schools. During the KMA Interim Meeting this year, the dean of the University of Louisville School of Medicine was presented an AMA-ERF check in the amount of $9,895.19, while the University of Kentucky College of Medicine received $3,677.56. We wish to recognize the assistance of the Woman's Auxiliary and are pleased that they do receive credit for funds collected in Kentucky which assists them in competition with other state auxiliaries.

A project of the committee, this year, was in regard to the survey on the attitudes of KMA members concerning the concept of the clinical associate or physician's assistant. The survey results indicate that physicians are receptive to the utilization of this type of health worker. Complete details were published as a special article in *The Journal* and a segment of the Interim Meeting this year concerned this concept. The committee feels the creation of new types of health manpower has a great deal of merit, particularly in a time when the demand for health services is ever increasing.

In an attempt to bring about closer liaison with the students of both medical schools, the committee asked each medical school SAMA Chapter to appoint a representative to attend our meetings. In addition, as in the past, two members of KMA were asked to be representatives to SAMA so there would be proper representation at the Commonwealth's two medical schools. Hoyt D. Gardner, M.D., was asked to be the representative to the University of Louisville, and Donald E. Edger, M.D., was asked to be the representative to the University of Kentucky. Their individual reports will follow as an addendum to this report.

Since the activities of the Medical Education Committee have increased this year, two special subcommittees were formed, both under the chairmanship of committee member, Frank R. Lemon, M.D. One subcommittee planned the 1971 Conference on Medical Education which will be held at Park Mammoth Resort, January 23 and 24. We are of the opinion that this is a very important function of the committee, in that it gives physicians in private practice and academic medicine the opportunity to meet and exchange ideas.

The other subcommittee was formed to develop a survey to determine the continuing medical education needs of Kentucky physicians. The endeavors of both subcommittees will be actively pursued during the next Associational year and the members serving on them are to be commended for their untiring efforts on behalf of KMA.

The concept of continuing education as a requirement for membership in medical societies or for relicensure by states was also discussed by the committee. We feel that this type procedure is becoming more prevalent throughout the country and that the initiative must be taken by the private sector in setting up these programs. We have contacted the various state medical societies currently involved with these types of programs and hope to examine those which are now in existence, in the event KMA should decide to undertake a similar line of action.

The Postgraduate Medical Education Fund continues to be supervised by this committee. The committee approved the use of $850 from the fund by the KMA Educational Television Committee in their effort with the PANMED continuing medical education television series.

In addition, your committee also selected the recipients of the KMA Faculty Scientific Achievement Awards to be presented during the Annual Session.

I, as Chairman, would like to thank the members of the committee: Douglas M. Haynes, M.D., William S. Jordan, Jr., M.D., Frank R. Lemon, M.D., Elmer G. Pruitt, M.D., Carl H. Scott, M.D., and William J. Temple, M.D., for their efforts and cooperation during this Associational year.

Walter I. Hume, Jr., M.D., Chairman

SAMA Representative to the University of Kentucky College of Medicine

This representative holds a similar position in the Fayette County Medical Society along with several committee members. We have met on several occasions with the officers of the University of Kentucky Chapter of the Student American Medical Association. Our efforts at the present are directed toward a program to be presented to the Fayette County Medical Society by the University of Kentucky Medical Students. The program has not been developed as yet, but its content will be determined by the students themselves. I envision this program to be sort of a Senior Day Program in reverse, that is, a session where the students can tell the "Establishment" something of their basic philosophies.

Some degree of dialogue is taking place here but I am not sure that either party has heard anything meaningful.

Donald E. Edger, M.D.
KMA Representative to SAMA
University of Kentucky

SAMA Representative to the University of Louisville School of Medicine

Numerous contacts with this chapter have occurred throughout the year, including accompanying them to the annual, national Student AMA convention in Philadelphia.

During the course of this past year, through the agencies of the local chapter at the University of Louisville, they have instituted the person to person approach to medical students to areas of medical need and formed the Greater Louisville Organization For Health. This will apply itself to the indigent and needy medical areas, located in the Russell area of the city of Louisville. It will be staffed by the interested medical students, student nurses, student dentists and other type students, under the supervision of volunteer M.D.s. This received the unanimous endorsement of the Jefferson County Medical Society and the encouragement of other health organizations throughout the area. They are now in the process of recruiting funds, as well as the establishment of the appropriate building location to begin the summer project.

The general proclivity of current medical students to interest themselves in the health delivery, particularly the indigent, needy and the unknowledgeable, is bringing some new dimension to medical school years.

During the past year, Bill Moss, brother of past national SAMA President, James Moss, served as regional Vice-President to SAMA. The local chapter participated in several of the regional projects.

As per past precedent, our usual contribution to the travel expenses to the annual convention in Philadelphia was disbursed and gratefully received.

It is easy to see that the complexions of medical schools, as evidenced by the new curricular and the numerous elective subjects, has given the students more opportunity to look at the broad visage of medicine and some of them have found the necessity to supplement their sensitivities in medicine by bringing expression to the ghetto and other undermedically privileged at a very early age. What the final result in regards to the overall contributions to health care and to organized medicine, as well as to the supplementation of medical education, remains to be seen. So far, it seems to have been well received and is praiseworthy and from the national level, the American Medical Association has funded several projects of this nature.

It has been a pleasure to serve in the capacity of the above. It has been most stimulating and challenging to work with young men. Their new ideas and complexions are always an experience that physicians are glad to share and have.

Hoyt D. Gardner, M.D.
KMA Representative to SAMA
University of Louisville

Recommendations, Reference Committee No. 2

The Report of the Committee on Medical Education was reviewed with interest. The committee noted that the Kentucky Medical Association, through its representatives, is maintaining contact with the SAMA Chapters at both medical schools in the state. We would like to compliment this Committee on Medical Education for its thorough and excellent report.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Hospital Committee

The KMA Hospital Committee met twice this year, on December 4, 1969 and May 28, 1970. The activities of the committee have substantially increased this year, as witness the fact that your chairman and individual members have attended some ten meetings on committee business in addition to the two formal meetings mentioned above.

On October 29-30, your chairman, along with representatives of KMA, KHA, the Kentucky Department of Health, the Title XVIII Intermediary, and HEW and SSA representatives met with administrators, boards of trustees and medical staffs of hospital based extended care facilities experiencing difficulties with low utilization of their ECF beds. These meetings resulted in a number of recommendations being made which, hopefully, will relieve this problem. In addition, the Comprehensive Health Planning Council is now aware of this situation and is taking positive steps, through the various agencies concerned, to correct it.

The committee also discussed the proposal of constructing a hospital in the Commonwealth, the sole purpose of which would be to treat and rehabilitate serious burn cases. The proposal was brought to us by O. M. Patrick, M.D., Frankfort, on behalf of the Kentucky Firemens Association.

Doctor Patrick presented the fact that the firemen want to do something for the state community by building a Burn Hospital and feel that they can raise some money, and it is our understanding that they feel they can sustain the operation. The committee recommends that the Board of Trustees and House of Delegates commend and encourage the firemen for this idea in that it is desperately needed in the state. They believe that there are about 3,500 burns a year that need to be taken care of and that these burns are probably not being taken care of as efficiently and economically as they should be. Hospitalization is probably too long and more expensive than it should be. We believe that the cost could be reduced both in present-day treatment and in the number of days, and that mortality and morbidity could be reduced.

We also believe that burns serve as a very important educational tool in the teaching of medical educators and house staff and that this is another reason for having a burn center located in a teaching center. The committee recommends that the firemen consider two burn centers, one at each medical school in the state, and we realize that the attitude of medical schools will have to be explored.

The committee does not know, but it feels, that the cost of a separate building, no matter how proximate, would be greater than the cost of a unit within a hospital. Not only the initial cost, but the sustaining cost, should be less if the laboratories, laundries, nursing staff, administrative staff, and medical staff could be used at least part time for other functions. The committee realizes the allure to an organization, such as the firemen, in having its own separate building, but we feel this is a chimera that they should not follow because of expense. The committee feels adequate figures cannot be developed to demonstrate the best method of developing a burn unit. (The best method means the ability to treat the most burns for the least dollars in a quality way.) The committee recommends that the State Comprehensive Health Planning Council, along with the firemen, make a study availing itself of the cost at the various Shriner hospitals and the medical colleges such as the Medical College of Virginia at Richmond. The committee feels that it is our responsibility to help control the ascending cost of medical care and that a committee of informed hospital administrators, plastic surgeons, medical educators, and laymen, could give a verdict which the firemen, state medical association, and Comprehensive Health Planning Council should abide by.

Our "Dry Run" Hospital Accreditation Team visits have continued to be available to the hospitals in the state. As our activities in this area have increased, we made additions to the number of individuals available to our teams, and wish to express our appreciation to these individuals for their time and effort. In addition, we have met with representatives of hospital staffs and hospital boards of trustees to assist in seeking solutions to problems confronting the efficient operation of hospitals.

The KMA Hospital Subcommittee on Coronary Care Units, under the able chairmanship of Henry W. Post, M.D., Louisville, met on May 27 to discuss the ROCOM means of education on coronary care units, as requested by the KMA Board of Trustees. After addressing itself to the availability of that unit, the subcommittee learned that two ROCOM units will be available in the state after August 1, 1970 through the auspices of the Ohio Valley Regional Medical Program.

The subcommittee also discussed another avenue of the educational aspect of coronary care units which might involve educational television. They feel that this should be explored as a combined effort of the KMA Committee on Educational Television and Coronary Units Subcommittee in conjunction with the Kentucky Heart Association and the two medical schools in the State of Kentucky. Doctor Post and the members of his subcommittee are to be recognized for their efforts in this regard.

The KMA Hospital Committee strives to maintain liaison at both the national and local levels, and through the cooperative effort of allied groups, to be of maximum service to you.

James B. Holloway, Jr. M.D., Chairman

Recommendations, Reference Committee No. 2

The Report on the KMA Hospital Committee was considered and reviewed with interest. The Kentucky Firemens Association's idea of supporting a hospital for burn cases for the State of Kentucky is certainly interesting and should be explored further. This committee has had a busy and productive year for which we wish to express our appreciation.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Educational Television Committee

After several years of planning by the Educational Television Committee, weekly telecasts began this year. These programs carried on the Kentucky Educational Television network throughout the state and on WKPC-TV, Channel 15, in Louisville, have been produced by University of Kentucky Television using the series name PANMED. University of Kentucky and University of Louisville Medical Centers are both represented on the committee and have provided guidance in program selection.

Financial support for programs this year has been obtained through grants from the American Cancer Society, Kentucky Division, and the Kentucky Heart Association. A separate grant from the Ohio Valley Regional Medical Program was obtained to allow surveys of the effectiveness of this series.

The series has consisted of medical programs broadcast once each month interspersed with programs devoted to dentistry, nursing, pharmacy and allied health fields. The programs, mostly 30 minutes in length, have consisted chiefly of pre-taped material sometimes supplemented with studio presentations. This has been considered the most economical method at this time. In the future, if sufficient funding can be obtained, more involvement of Kentucky physicians in the production of these programs is anticipated.

As a result of OVRMP survey and two other surveys conducted at the beginning and at the end of the series the committee members feel that efforts should be made to continue this project. Increasing numbers of physicians are becoming aware of the programs and indicated their interest.

Efforts are being made to obtain funding through the same and similar sources used last year to enable another year of operation. At sometime in the future, it seems likely that a more permanent method of financial support of this venture will have to be sought.

Thomas L. Heavern, M.D., Chairman

BOARD ACTION: Approved, with the request that more detailed information concerning the surveys be made available to interested persons.

Recommendations, Reference Committee No. 2

The Report of the Educational Television Committee was read and discussed. The reference committee believes that educational television is becoming better known to the physicians of the state and hopes that it will continue this progress. The reference committee wishes to express its appreciation to the Educational Television Committee for its efforts and accepts this report as presented.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Disaster Medical Care Committee

We have had a busy year with much planning and not much production.

Your Committee has been concerned about the lack of disaster preparedness at the commercial airports in Kentucky. Because of his experience at the Greater Cincinnati Airport, located in Boone County, Robert E. Reichert, M.D., has agreed to investigate and make recommendations about this problem. Considerable time was spent on the development of transportation services for the sick and injured under emergency conditions. The Committee was charged with seeking helicopter transportation. particularly for complicated pregnancy cases. Unfortunately, the military services are not able to supply this service. The Committee continues to investigate other sources of helicoptor transportation.

The 1970 revised statement of the American College of Surgeons concerning the hazards of the speeding ambulance was mailed to the president of each county medical society. The services of the Committee and Staff were offered to implement the suggestions of the American College of Surgeons. Your Committee has expressed a desire to appear at the county society meetings to discuss emergency medical services. We hope that invitations will be coming from the county society program committees.

The Committee once again stated that there must be standards for the training of ambulance attendants. However, the fulfillment of these standards should be on a voluntary basis until such a time as adequate arrangements have been made by governmental services to supplement the efforts of privately owned ambulance systems whenever necessary.

The Committee sent a telegram to the Comprehensive Health Planning Council requesting that organization to establish a Study Committee on Emergency Medical Services. The Council has done so and the chairman, Frederick A. Stine, M.D., of Covington, has shown great leadership in the development of the committee.

Communications for emergency medical services have been improved by the development of an emergency radio communications network to serve 12 hospitals throughout southeastern Kentucky. This is the first rural system of its kind in the United States. The Kentucky Medical Association was instrumental in working with the Kentucky Hospital Association in development of this program.

The posting of hospital signs on the interstate highway system has continued. The reaction to this program has been most favorable.

During the past legislative session there was considerable discussion about hospital emergency rooms and staff problems. The legislative proposals on emergency medical services were very ineffective because of the lack of coordination between the Kentucky Department of Health and the Kentucky Medical Association. A bill was passed permitting cities to contract with private ambulance services

for transportation providing the ambulance attendants meet certain standards and the ambulance carry the essential equipment as listed by the American College of Surgeons. The U. S. Jaycees have indicated an interest in the problem of emergency medical service. Your Committee has made initial contact with the Kentucky Jaycee organization relative to this matter. We hope that they will be interested in the development of some of our programs.

The Committee will sponsor an exhibit on "Tetanus Immunization" at the Annual Meeting.

The chairman of the Committee met with William P. McElwain, M.D., the Commissioner of Health, to discuss the mutual problems of emergency and disaster medical care. Doctor McElwain was most cordial and seems receptive to the suggestions of the Committee.

William T. Rumage, Jr., M.D., Chairman

Recommendotions, Reference Committee No. 2

The Report of the Disaster Medical Care Committee was reviewed and it is evident that this has been a busy year for this committee. They have been concentrating on transportation of sick and injured patients which is becoming of greater importance daily. The reference committee compliments this committee on its effective work during the past year.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Cancer Coordinating Committee

The Cancer Coordinating Committee was established two years ago to coordinate cancer follow-ups and reporting in the fourteen approved Kentucky hospital cancer registries and the State Cancer Registry.

No specific requests have been made of the Committee this year; consequently, no meetings were held.

Condict Moore, M.D., Chairman

Recommendotions, Reference Committee No. 2

The Report of the Cancer Coordinating Committee was read and accepted as presented.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Ad Hoc Committee on Emergency Medical Care Planning

The Emergency Medical Care Planning Committee was formed to work out details for an Emergency Medical Care Planning Forum. Due to considerable difficulty in determining a proper time for this meeting and to problems in financing of the forum, the meeting was not held.

Recommendotions, Reference Committee No. 2

The portion of the Report of the Chairman, Board of Trustees, pertaining to the Emergency Medical Care Planning Committee, was considered and accepted.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Resolution F

Campbell and Kenton County Medical Society

WHEREAS, neighboring states including Indiana and Ohio license graduates of foreign medical schools, who have filed first papers for citizenship and have passed examinations for medical licensure comparable to those given in the states in question; therefore be it

RESOLVED, that the Kentucky Medical Association Board of Trustees propose a change in the Kentucky Revised Statutes pertaining to Medical Licensure by endorsement to conform with subheading VII—Licenses without Examination—Paragraph (a) Endorsement: of *A Guide to the Essentials of a Modern Medical Practice Act,* published by the Federation of the State Medical Boards of the United States, Inc., 1970 Revised Edition. That is: "It is recommended that a licensing agency may issue a license by endorsement to an applicant, who has complied with licensure requirements, and who has passed an examination for licensure to practice medicine in all its branches in any other state or territory of the United States, provided that the examination endorsed was, in the opinion of that agency equivalent in every respect to its examination."

Recommendotions, Reference Committee No. 2

Resolution F, concerning Foreign Graduate Licensure, introduced by Campbell-Kenton Counties, was reviewed by the reference committee and it is felt that a complete definition of the words "endorsement" and "licensure requirements" be obtained before recommending a change in the Kentucky Revised Statutes pertaining to Medical Licensure. The reference committee also thought that instead of a blanket reciprocity, it should be by individual states.

The reference committee recommends that Resolution F be referred back to the Campbell-Kenton County Medical Society for clarification and resubmission to the Board of Trustees or House of Delegates at a later date.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded.)

During the discussion of this resolution, a motion was made, seconded and passed to strike the words "or House of Delegates at a later date" in the Reference Committee report above. The original motion was then adopted as amended.

Resolution M

Jefferson County Medical Society

WHEREAS, the Kentucky General Assembly of 1970 saw fit to pass a law requiring Departments of General or Family Practice in the state subsidized Medical Schools by July 1, 1970, and

WHEREAS, the two Medical Schools involved have both indicated they do not expect to have such Departments in the Medical Schools formed and active before mid-1972, and

WHEREAS, the leadership of both Schools has openly stated their opposition to forming such Departments in the Medical Schools, and

WHEREAS, the 1972 General Assembly will have been in session at the time indicated for probable completion of such Departments by the Medical Schools, and

WHEREAS, similar problems of forming Departments of General or Family Practice in other Medical Schools have been easily and much more quickly and effectively accomplished in as little as one year of effort, and

WHEREAS, the opinions of advisors and interested parties not in the Medical Schools, are that the forming of such Departments in the Medical Schools could with sincere effort and approach be in effect by July, 1971, and

WHEREAS, prolonged planning with no accompanying effective action is considered by advisors and interested parties as possibly a stalling maneuver to avoid formation of such a Department, therefore be it

RESOLVED, that the KMA support a very rapid and effective formation of strong General or Family Practice Departments in both Medical Schools with a target date of July 1, 1971, to be considered as an adequate time to comply with the existing state law.

Recommendations, Reference Committee No. 2

Resolution M, concerning Departments of General Practice, introduced by Jefferson County, was read and studied at length. A number of concerned officials were present and gave their opinions concerning this resolution. The reference committee appreciates the sincerity and the interest of both medical schools concerning this problem and also the general practitioners and state officials who are actively concerned with implementing programs of family practice. The reference committee decided to recommend that this resolution not be adopted and that a substitute resolution be submitted which is as follows:

"WHEREAS, the Kentucky General Assembly of 1970 saw fit to pass a law requiring creation of Departments of General or Family Practice in the state's supported medical schools by July, 1970, and

WHEREAS, the two medical schools involved have indicated they may not have such departments formed and active during the current fiscal year (1970-71), and

WHEREAS, problems have not existed in some other state medical schools in easily and quickly forming Departments of Family Practice, and

WHEREAS, both schools indicated definite willingness to rapidly implement the intent of the legislation if adequate and sustained new funding can be obtained, therefore be it

RESOLVED, that the Kentucky Medical Association support rapid and effective formation of strong General or Family Practice Departments in both medical schools in the State of Kentucky and seek to obtain broad public support of proper funding of these departments at the earliest possible date so these programs can be successfully implemented in order to provide more family practitioners for Kentucky."

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded.)

(Following discussion, the motion was adopted.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 2 as a whole as amended.

(Motion was seconded and carried.)

As Chairman of Reference Committee No. 2, I wish to express my appreciation to the members of the committee for their cooperation and mature considerations of the matters brought before this committee. They are Doctors Bosomworth, Huntsman, Solomon, and Willoughby.

REFERENCE COMMITTEE NO. 2
Faull S. Trover, M.D., Madisonville, Chairman
Peter P. Bosomworth, M.D., Lexington
Harry B. Huntsman, II, M.D., Greensburg
Edwin P. Solomon, Jr., M.D., Louisville
James O. Willoughby, M.D., Bowling Green

REFERENCE COMMITTEE NO. 3

Cecil L. Grumbles, M.D.,
Louisville, Chairman

Reference Committee No. 3 considered the following reports:

23. Report of the Committee on Occupational Health, Physical Medicine and Rehabilitation
24. Report of the Maternal Mortality Study Committee
30. Report of the Committee on Legislative Activities. Last paragraph on page 33 and paragraphs 1 and 2 on page 34 referred to reference committee No. 6
31. Report of the Committee on Orientation
32. Report of the Committee on Health Careers
35. Report of the Cults Committee
5. Report of the Chairman, Board of Trustees, Occupational Pulmonary Disease Committee Report only
5. Report of the Chairman, Board of Trustees, Ad Hoc Chiropractic Committee Report only

Report of the Committee on Occupational Health, Physical Medicine & Rehabilitation

The Committee on Occupational Health, Physical Medicine and Rehabilitation held one committee meeting during the Associational year on May 20, 1970.

The committee has attempted, during the past Associational year, to keep abreast of various legislative changes which took place in air and water pollution control due to actions of the 1970 General Assembly. The committee discussed the fact that the Kentucky Air Pollution Commission membership had been increased during the 1970 General Assembly. It was noted by the committee that five representatives of government are already on this commission and the only member representing the medical profession is an ex-officio member who actually represents the Department of Health. The committee feels that one of the three public vacancies created by the 1970 General Assembly should be filled by a physician.

As a result of the committee's recommendation during the 1969 Associational year, the Board of Trustees in 1970 authorized the appointment of an Ad Hoc Committee to Study Occupational Pulmonary Disease. The Ad Hoc Committee assumed a considerable amount of responsibility of this committee, and met a number of times during the Associational year. It is felt that the establishment of the Ad Hoc Committee was a real step forward in giving more opportunity to study the problems of Occupational Pulmonary Disease in Kentucky.

The committee recommended to the Board of Trustees that positive legislative programs be implemented through the State Legislative Affairs Committee for presentation to the General Assembly in 1972. This proposal would include specific recommendations in the field of Occupational Health, Environmental Health and Rehabilitation.

The committee continues its interest in seeing

that all injured workers are rehabilitated whenever possible so they can become requalified for re-employment. It is still felt that changes could be made in Kentucky's Workmen's Compensation laws which would facilitate this goal.

The chairman is grateful for the time and effort expended by the committee members this year.

John E. Eckerle, M.D., Chairman

Recommendations, Reference Committee No. 3

The Report of the Committee on Occupational Health, Physical Medicine and Rehabilitation was reviewed. It was felt by this committee that specific emphasis should be placed on the recommendation that a physician be appointed to fill one of three vacancies on the Kentucky Air Pollution Commission. The reference committee encourages the committee to continue their interest in legislation affecting the workmen's compensation laws.

We would like to express our appreciation to this committee for its effective work in this field of occupational medicine.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Maternal Mortality Committee

The Maternal Mortality Committee of the Kentucky Medical Association held two meetings to discuss anonymously, by number only, each death associated with pregnancy. As in the past, these cases are discussed one year after each occurrence.

We have continued to use appropriate cases in *The Journal* with editorial comments intended for constructive purposes.

John A. Petry, M.D., Chairman

Recommendations, Reference Committee No. 3

The report of the Maternal Mortality Committee of the Kentucky Medical Association was reviewed by this committee. It was noted that the discussion of the Maternal Mortality cases in the *KMA Journal* have been read with great interest by many members.

We would like to commend the Maternal Mortality Committee members on their effective work.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Committee on Legislative Activities

National Affairs

The Committee on Legislative Activities has met frequently in the past year, due to its being a State Legislative year. Sometimes it was necessary to meet weekly to stay abreast of rapid considerations taking place.

There has been the usual large number of bills in the Federal Congress, which to date is the 1st Session of the 92nd Congress, of which approximately 1,000 have specific medical applications.

The following is a general breakdown by subject, description and status of the more significant ones:

SUBJECT	DESCRIPTION	STATUS
National Health Plans		
(a) AMA's Medicredit Similar plans HR 9835 S 2705	Tax credits for purchase of health insurance; federal subsidization of premium purchase for poor, not yet introduced NYI	Testimony was given House Ways and Means Committee last fall on this general subject, but there was no action. A Senate Labor and Public Welfare Sub-committee is expected to hold hearings on general subject of national health insurance.
(b) Reuther Plan	Payroll tax plus general revenue financing of national health insurance NYI	
(c) Griffith bill (generally endorsed by AFL-CIO) HR 15779	Unlimited hospitalization and physician care for all financed by Social Security and general revenues with emphasis on pre-negotiated rates and pre-paid group practice arrangements.	Introduced
(d) Javits Plan	Extends Medicare to cover all	Introduced April 14
(e) Kennedy Plan	NYI	
(f) Medicare	Extend Medicare to cover all ages; Social Security financing NYI	
Medicare-Medicaid	Administration's proposal for new Part C Medicare pre-paid plan, peer review, discontinuance of payments authority, incentive grants, etc.	Being considered at Ways and Means hearings, as are other changes in the Medicare-Medicaid programs, including coverage of disabled, outpatient drugs. AMA proposed federal subsidy of premium purchase for poor in Medicaid.
	A separate administration proposal to link physicians' fees to the cost of living, made to the Senate Finance Committee, not yet introduced.	
	Administration bill to expand Medicaid outpatient benefits, limit extended care.	One of the proposals being studied by Ways and Means Committee of House.

Narcotics S 3246	Administration-backed bill giving Justice Department classification powers, "no-knock" enforcement right, easing possession penalties	Passed by Senate.
HR 11701 HR 13743	House-introduced measures would retain classification powers in HEW Department	Hearings held House Commerce Committee
Drug Rehabilitation S 3562	Separate HEW agency to operate rehabilitation programs, construction grants, research	Hearings under way by Labor Subcommittee of Senate
Health Manpower	Aid for medical education	Expires June 30. Administration bill to be submitted with expected changes in present program.
Drug Abuse Education S 3134 HR 9312	$10-million-a-year program of educating youth on drug abuse dangers.	Approved by House 294-0
Hill-Burton HR 11102	Extend and enlarge Hill-Burton Hospital aid minus administration loan guarantee proposal, which is being proposed again this year.	Passed House June 4. Senate Labor and Public Welfare Committee approved broader bill.
Water Pollution PL 91-224	Tighten water purity standards, prevents oil spills, dumping	Passed Congress.
Regional Medical-Comprehensive Health S 3443 (Adm) S 3355 HR 14284	Grants for developing state plant to coordinate health efforts; extension Regional Medical Programs. Administration proposes merging 2 programs.	Hearings held by Senate Labor Subcommittee.
Allied Health Professions HR 13100	Three-year extension of aid for training allied health personnel	Early hearings expected. Expires June 30.
Occupational Health HR 13373	Standards, advisory committees to Secretary of Labor	Hearings held in House and Senate. Approved by House Commerce Subcommittee
Birth Control S 2108 S 3219	Multi-million dollar program for family-planning services.	Hearings held by Senate Health Subcommittee.
Communicable Diseases S 2264	Extends vaccination assistance control programs for TB, VD.	Passed Senate. Before House Commerce Committee.
Air Pollution S 2388	Sets up an Environmental Quality Administration to consolidate federal anti-pollution work, federal standards.	Hearings in House and Senate.
GPs S 3418	Large federal program to train more family physicians.	Introduced by Senator Yarborough (D. Texas)
Constitutional rights of mentally ill	Safeguard rights of committed persons.	Hearings held before Senate Judiciary Subcommittee.
Health Department HR 14238	Cabinet-level Department of Health	Introduced by Representative Brown (R. Ohio)
Medical Devices	Pre-marketing FDA clearance of medical devices.	No hearings to date.

Because of the extreme importance of National Health Insurance Plans being considered, that KMA membership and leadership be apprised of the current proposals and their more significant features, the following table will present this:

PLAN: American Medical Association "Medicredit"

PURPOSE: To encourage all persons to be protected against expense of illness. Uses private insurance carriers stating that competitive system provides incentives for lowering costs, innovations in delivery of care, and maintenance of quality.

HOW IMPLEMENTED: Taxpayer may purchase "qualified" insurance policy and takes credit (based on his tax liability) on tax return for part of premium cost; or, if in lower 30% income group, receives certificate good for full cost of premium.

METHOD OF FINANCING: Income tax credit ranging 10% of premium cost to 100% depending on family tax liability; lower 30% of taxpayers to receive certificate covering 100% premium cost.

GOVERNMENT PARTICIPATION: Federal financing through tax credits and "certificates"; state approval of insurance company and plan; an independent Health Insurance Advisory Board sets guidelines.

WHO IS INCLUDED: All persons under 65, except military. Elderly's cost of Part B, Medicare plan also included.

BENEFITS INCLUDED: Basic: All M.D. and osteopathic services plus 60 days hospital; Supplemental: drugs, other personal health services. For over 65 person: the Part B, Medicare program.

ANNUAL COST: Estimated $10.2 billion total, less savings of Federal share of Title XIX ($2.6 billion); Net federal cost $7.6 billion.

PLAN: Tax Credit Bills of Fulton (HR 9835; and Fannin (S 2705)

PURPOSE: To make it possible for every citizen to obtain comprehensive medical and hospitalization insurance of his choice on guaranteed renewable basis.

HOW IMPLEMENTED: Provides for voluntary health insurance coverage for all persons, with the federal government's financial participation based on the taxpayer's income. Taxpayer takes credit on his tax return or receives insurance premium certificate.

METHOD OF FINANCING: Income tax credits based on taxpayer's adjusted gross income, credit ranging from 25% (over $10,000 income) to 100% (under $2500 income). Maximum federal contribution $400 per family.

GOVERNMENT PARTICIPATION: Federal financing through tax credits and insurance premium certificates. State approval of insurance company and plan.

WHO IS INCLUDED: All persons.

BENEFITS INCLUDED: As may be offered by individual insurance company; also, for over 65 persons, the Part B, Medicare program.

ANNUAL COST: Not stated.

PLAN: Congressman Durward Hall

PURPOSE: To provide a two-part program; first, to do away with Medicaid; second, (at later date) to provide protection against catastrophic illness.

HOW IMPLEMENTED: Part I: Federal government to pay cost of health insurance policy for "Medicaid" individual. Part II: Establishes a federal pool of general revenue funds to cover "catastrophic" illness of all persons.

METHOD OF FINANCING: Part I: Federal, through payment of cost of insurance certificate; Part II: From federal general revenues.

GOVERNMENT PARTICIPATION: Federal: financing and setting of policy minimum benefits. State: approves insurance carriers, including Blues.

WHO IS INCLUDED: Part I: Title XIX recipient. Part II: All others when faced with catastrophic illness.

BENEFITS INCLUDED: Part I: Basic coverage as defined by Congress (about 85% of health care expenses); Part II: catastrophic health care expenses.

ANNUAL COST: Part I: $3.5 billion. Part II: Not stated.

PLAN: "Committee of 100"—Walter Reuther

PURPOSE: To provide a national health insurance plan which would restructure the delivery system and pay for all personal health care, including hospital, medical and dental.

HOW IMPLEMENTED: Administered by HEW, with Advisory Council including representatives of consumers and providers; would absorb Medicare, Medicaid, and many other collateral programs.

METHOD OF FINANCING: Contributions from employers, employees and self-employed, and from general tax revenues; also provision to permit employer to assume employee's payment. Estimated: two-thirds, employer-employee; one third, federal.

GOVERNMENT PARTICIPATION: Sets up broad federal involvement in the whole structure of health care delivery; provides for federal standards for care and federal licensure of providers.

WHO IS INCLUDED: All persons.

BENEFITS INCLUDED: All diagnostic, medical and surgical care; hospitalization; dental; nursing home; home health services; drugs, appliances, hearing aids, eyeglasses; other health services.

ANNUAL COST: Estimated at $40 billion, annually.

PLAN: Rockefeller—Javits

PURPOSE: To provide for a compulsory system of insurance against costs of basic health services.

HOW IMPLEMENTED: Establishes a Health Benefits Commission to implement program; requires employers to maintain insurance or other program covering health needs of employees; covers unemployed through "pool" funds.

METHOD OF FINANCING: Employer-employee contributions; for indigent: from federal, state and local contributions to pool.

GOVERNMENT PARTICIPATION: Part federal financing; federal appointed commission to provide for benefits and to control costs; involves state health planning agencies.

WHO IS INCLUDED: All persons; eventually to replace Medicare and Medicaid.

BENEFITS INCLUDED: 90-day hospital services on a semi-private room basis; out-patient hospital services; home health care; physician services.

ANNUAL COST: Not stated.

PLAN: Senator Edward Kennedy

PURPOSE: To bring high quality medical care to all persons by 1975.

HOW IMPLEMENTED: Implemented in stages. 1971: Include coverage for all infants, preschool children, and adolescents in elementary and secondary schools; next four years expand at rate of 10 year age group per year.

METHOD OF FINANCING: Through federal general treasury revenues, with sufficient guarantees to avoid the vagaries of the appropriation process.

GOVERNMENT PARTICIPATION: Federal financing.

WHO IS INCLUDED: 1971: preschool and school children; broadened each of next four years at rate of 10 year age group per year; eventually include entire population.

BENEFITS INCLUDED: As comprehensive as possible.

ANNUAL COST: Not stated.

PLAN: AFL-CIO

PURPOSE: To provide a system of universal health care coverage for all persons.

HOW IMPLEMENTED: A federal program allowing providers (physicians) to practice in the system on a full or part-time basis, or of remaining out of system.

METHOD OF FINANCING: Tripartite basis: one-third, employer; one-third, employee; one-third, general revenues.

GOVERNMENT PARTICIPATION: Federal management and control; somewhat similar to Medicare.

WHO IS INCLUDED: All persons.

BENEFITS INCLUDED: Hospitalization; all physician services; extended care; custodial care; home health services; eye examinations; prescription drugs.

ANNUAL COST: Not stated.

The Annual Washington Congressional Dinner for KMA was held on June 1 and 2, 1970, in Washington, D. C., with a tour of the Capitol and a visit to each of our seven Representatives and two Senators. The affairs of the country concerning medicine were appropriately discussed with them. We also wish to commend the AMA Washington office, under the direction of Harry Hinton, for the excellent briefing and orientation given on Monday night, June 1. The high quality and effectiveness of this staff were readily apparent to all of us.

There was a record turnout of physicians and wives for this trip, and also we had the pleasure of the new State Health Commissioner, William P. McElwain, M.D., accompanying us on the trip.

The dinner was held as usual in the Mayflower Hotel, and it was our pleasure and pride to have the Representatives and Senators and their administrative assistants join us.

A critique visit was held on the afternoon of June 2, and a general review of strategies from discussions was held.

The format was changed this year in order for the briefing session to be held on Monday night rather than early morning of the Tuesday of the Congressional Dinner. A biographical sketch of Congressmen was presented to all in attendance, and a map of the Capitol was provided to each to help mobility and quick identification of buildings. The general agenda was improved over previous visits and will be continued next year.

This year in Kentucky is an election year, and, more significant, all Congressmen are standing for re-election. The members of the Committee on Legislative Activities encourage and endorse KEMPAC activities and urge all KMA people to join and to participate in order that we may have a more significant legislative impact.

The committee members wish to express appreciation to Gil Armstrong, Jerry Mahoney, Bill Applegate, and to our Executive Director, Bob Cox, for their outstanding help and assistance this past year.

Hoyt D. Gardner, M.D.
Chairman for National Affairs

State Affairs

The KMA Committee on Legislative Activities has concluded an extremely busy year. The full committee met on November 13 and December 11 of 1969, and January 15, February 5, February 23 and March 10 of 1970.

Although the full committee met only on these six occasions, the committee members were very

busy. In no way does the number of meetings reflect the amount of involvement since a large number of proposals were acted upon by the Quick Action Committee.

The Key Man Orientation Program was held in Frankfort on January 15. In addition to these meetings, the Chairman for State Affairs attended the AMPAC Workshop in Washington and the KMA Congressional Dinner in Washington, as well as some of the trustee district meetings.

Most of the committee members made numerous and frequent visits to Frankfort while the Legislature was in session, as well as carrying out other assignments as designated by the Chairman for State Affairs.

The Chairman for State Affairs usually traveled to Frankfort on Monday afternoon and stayed until Wednesday night or Thursday morning, except during the waning week or so of the session when more time was required.

This session of the Kentucky General Assembly was much more active than any in the past due mainly to the functioning Interim Committee system and better organization of both the House of Representatives and the Senate. During past sessions, very few bills were introduced during the first few weeks of the session, whereas when this session convened, over 200 bills were already prepared and ready for introduction giving this session of the Legislature a much more rapid pace than the prior sessions. A total of 1,385 bills and resolutions were introduced, 138 of them having medical implication.

We were very fortunate to have many legislators vitally interested and genuinely concerned about good health legislation for the Commonwealth Therefore, we were able to gain passage of all of KMA's major positive legislative proposals (with only one veto) including the Uniform Anatomical Gift Act, the Venereal Disease Bill, and the much-discussed, long-studied, TB Merger Bill. Likewise, we were pleased to see defeated all of the bills to which we were opposed and which we felt were of major concern, with the exception of one bill which was amended to meet some of our objections. Some of these proposals will undoubtedly be considered again in the next session and, therefore, demand our study and consideration; namely, the generic drug proposal and the reorganization of the State Board of Health. It is our considered opinion that KMA should continue to stress our positive legislative goals as we did in this and the prior sessions of the Legislature.

Needless to say, the perennial chiropractic proposals were once again introduced (a total of seven bills), none of which were ever reported out of committee. The members of KMA should continue and perhaps increase efforts to inform Legislators and the general public about the unscientific cult of chiropractic.

We were extremely fortunate to have two field representatives in Frankfort this session instead of one, both of them serving full time on legislative affairs while the General Assembly was in session. Mr. Gil Armstrong worked on the Senate side; Mr. Jerry Mahoney worked on the House of Representatives side. We strongly recommend that at least two staff men continue to be assigned full time to legislative affairs during the General Assembly since it is physically impossible for one man to constantly observe both chambers, to say nothing of the impossible number of legislative proposals to evaluate and to follow.

It would seem almost superfluous and yet necessary to remind our Association members that these staff men, throughout their stay in Frankfort, are reponsible only to their immediate superiors and not to individual Association members. The field men have been instructed not to carry out any recommendations or suggestions presented to them without first the approval of this committee or its proper representatives. Recognizing the sincere dedication of our staff people and personally knowing of the fantastic number of hours expended on behalf of our profession (for which they are not paid any overtime) it is most disturbing to learn of some of the actions and comments of a few Association members. We would strongly encourage all KMA members to contact the Chairman for State Affairs instead of the staff people regarding any information or recommendation which they might have regarding legislative affairs. We cannot commend too highly the performance and cooperation of Mr. Cox, Mr. Armstrong and Mr. Mahoney during the General Assembly.

The committee feels that greater emphasis must be placed on communicating with specialty groups and allied medical groups beginning as far as one year in advance of the next General Assembly to coordinate legislative proposals of mutual concern thereby improving our legislative base and programs. It is felt that with the new Commissioner of Health much better communications will be possible with the State Department of Health. This committee will continue maximum efforts to coordinate our activities with all specialty groups, individual physicians and all allied groups.

Continued efforts are being made to strengthen our Key Man System, and we wish to re-emphasize the importance of the key man as related to our legislative success or failure. These positions are extremely important and should not be accepted by anyone unless he has both the time and the interest to fulfill his obligation.

I think it is apparent to everyone involved in any aspect of medicine that more and more is demanded of our time and talents because of the increasing role of government and legislative matters affecting the practice of medicine.

We strive to fulfill our responsibility of bettering the public health, and this quite often requires defensive efforts on our part, as well as emphasizing our positive programs.

This committee strongly recommends to the House of Delegates that (as it has done in the past): (1) the Quick Action Committee composed of the KMA President, President-Elect, and Chairman of

the KMA Board of Trustees, be empowered to approve legislative decisions presented to them by this committee. It is absolutely impossible during legislative sessions to wait considerable periods of time for formal approval of legislative matters by larger committees; (2) require all legislative activities to be coordinated by and channeled through the Committee on Legislative Activities; and (3) the priority of various legislative proposals be left up to the Committee on Legislative Activities, as well as the timetable to be used on the introduction of proposed legislative matters. I feel that this is a very important consideration, and would urge the 1970 House of Delegates to take similar action leaving the composition, priority and manner of introduction of legislative proposals to the Committee on Legislative Activities.

If requested, I shall be most pleased to appear before any group or committee to expand on any subject which has been discussed in this report.

Once again, this committee cannot emphasize strongly enough the absolute necessity of physicians participating at the local level, not only in legislative affairs, but in primary and general elections as well. So often the members of our committee hear from legislators that the physicians in their local area have not been in contact with them. We urge all physicians to become interested in legislative matters and to stay abreast of legislative trends and effectively communicate their opinions to their respective legislators. We also strongly urge each physician to support the candidate of his choice both financially and by active campaigning on behalf of the candidate. It is extremely important for all physicians to maintain rapport with their legislators and even more so for the key men so assigned.

I wish to express appreciation to those members of the Committee on Legislative Activities, to the Quick Action Committee, to the KMA Board of Trustees and to the KMA House of Delegates for their considered support and understanding. I am also extremely grateful to our staff, Bob Cox, Gil Armstrong, Jerry Mahoney, and Bill Applegate, for the tremendous cooperation and assistance which they have given me during this most busy year.

Fred C. Rainey, M.D.
Chairman for State Affairs

Recommendations, Reference Committee No. 3

The Report of the Committee on Legislative Activities (with the exception of the last paragraph on page 33 and paragraphs 1 and 2 on page 34) was reviewed and discussed with interest.

National Affairs: The Report of the Committee on Legislative Activities, National Affairs, was reviewed. Attention should be directed to the study and dissemination of information to KMA members pertaining to the medicredit proposals by the AMA. The committee feels it is the most practical of the proposals listed.

The Annual Washington Congressional Dinner by KMA Report was reviewed with pleasure. It was noted that this was the most successful and well-attended Congressional Dinner to date. Our representatives and senators expressed appreciation to the KMA members and wives for their attendance.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

State Affairs: The KMA Committee on Legislative Activities for State Affairs was reviewed. This committee wishes to express our gratitude to the participants in the key man program and to others who gave so much of their time. We would urge that continued efforts be made to strengthen the key man system, and we wish to re-emphasize the importance of the key man as related to our legislative success or failure.

The reference committee wishes to endorse and approve of the Quick Action Committee. We feel that its usefulness has been demonstrated during the past year.

We wish to commend Doctors Hoyt D. Gardner and Fred C. Rainey for their untiring efforts on the Legislative Activities Committee.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Committee On Orientation

The Committee on Orientation held one meeting during the 1969-70 Associational year. This meeting was held on January 22, 1970, and the Orientation Programs for 1970 Interim and Annual Meetings were discussed at that time.

The Orientation Committee, as of the 1970 Associational year, took over some of the responsibilities which were formerly handled by the Communication and Health Education Committee. Since the Orientation Committee was responsible only for the Orientation Programs, it was determined that certain changes should be made in the program, and the Orientation Committee should be responsible for putting these changes into action during the 1970 Associational year.

The House of Delegates in 1969 had suggested that the Orientation Program be redesigned with an emphasis on brevity and some formality. During the meeting on January 22, 1970, a discussion was held concerning ways in which the Committee could implement the directions of the House of Delegates.

Concerning the idea of brevity and informality, it was felt that certain parts of the program which had been used for a number of years and were somewhat overlapping could be dispensed with in the new approach orientation. With this thought in mind, the slide presentation which was presented to the KMA Trustee Districts in 1969 was added as the opening portion of the Orientation Program. The speech which accompanies the presentation was recorded by Henry B. Asman, M.D., KMA Immediate Past-President, and it was the feeling of the Committee that this is an excellent means of informing new members concerning the interrelation of organized medicine at the county, state and national levels.

It has been said in the past that some of the Orientation Programs have been too lengthy. It was felt that several of the presentations could be combined, others could be deleted, and some new topics could be added. The Orientation Committee, after lengthy discussion and much consultation with everyone interested in the program, decided to follow a format which would cover, in addition to the slide presentation, the following subjects: (1) county medical society and community relations, (2) the American Medical Association, (3) the health insurance field, (4) peer-review, (5) cults, (6) medico-legal aspects, and (7) the physician's role in legislation and politics.

These are the subjects which will be covered in the Orientation Program during 1970 and will be revised as the committee and others feel is necessary to keep abreast of the changing scene in organized medicine.

Carl Cooper, M.D., Co-Chairman
Wyatt Norvell, M.D., Co-Chairman

Recommendations, Reference Committee No. 3

The Report of the Committee on Orientation was reviewed. The importance of the Orientation Program was recognized and the format changes were commended. An invitation should be extended to all members of KMA who have not participated in this program to attend future programs.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Health Careers Committee

Following the decision of the Board of Trustees to enlarge the charge of this committee to include the development and establishment of cooperative mechanisms relating the Kentucky Medical Association to programs in new or emerging health professions, the committee membership was increased to provide additional expertise in this area.

Meeting regularly, the committee has developed a set of recommendations for levels of endorsement which have been referred to the Board of Trustees for their consideration and action.

This committee believes the adoption of these recommendations could be the first step toward more intimate involvement in and cooperation with those innovative programs seeking the support and counsel of the Kentucky Medical Association.

Where such programs involve professions in the other health specialities, e.g. nursing, collaberative mechanisms will be developed with their respective organizations to assure proper channels of communication.

The Health Careers Committee continues as in the past to support the recruitment efforts of both the Auxiliary and Health Careers in Kentucky.

Joseph Hamburg, M.D., Chairman

Recommendations, Reference Committee No. 3

The Report of the Committee on Health Careers was reviewed. We wish to thank the members of this committee for their important contributions.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Committee on Cults

The KMA Committee on Cults met on November 20, 1969, to discuss what projects, in addition to those already underway, the committee would undertake this Associational year.

The committee agreed that it should be ever cognizant and keep under constant surveillance the advertisement of any health products, devices or schemes not in the public interest.

Over 300 copies of the book, *At Your Own Risk: The Case Against Chiropractic,* by Ralph Lee Smith, have been distributed to physicians attending the Orientation Courses, constituent member organizations of the Kentucky Allied Medical Council, other interested organizations, and members of the 1970 Kentucky General Assembly. Physicians were advised of the availability of this publication through information printed in the "KMA Communicator" and *The KMA Journal.* Members of the committee recommend the reading of this book by all physicians and that the book be placed in their office reception rooms so that it can be read by their patients.

The committee members were delighted to learn that the author of this book will be the featured speaker at the KMA President's Luncheon on Wednesday, September 23, during the KMA Annual Meeting.

During the year the AMA Committee on Quackery held a series of one-day Regional Conferences on Health Quackery, at which time legislative proposals and bills introduced into the various state legislatures were discussed. Your Chairman, who also serves on the AMA Committee on Quackery, attended two of these meetings, and one of the sessions was attended by a representative of the KMA staff.

During the 1970 session of the Kentucky General Assembly, bills were introduced by the Kentucky Association of Chiropractors which would have permitted payment to chiropractors under the Kentucky workmen's compensation laws; included chiropractic payment under Medicaid; and provided for chiropractic coverage under accident, health disability, workmen's compensation, sickness insurance, hospital agreements or medical service indemnity. Another bill would have provided for a fine or imprisonment for any licensed healing arts practitioner found guilty of slandering any other person so licensed. None of the chiropractic bills received favorable consideration.

KMA-sponsored bills were introduced into both houses of the Kentucky General Assembly. These legislative proposals would have required all professional healing arts schools to be accredited; chiropractors to complete the same written examination as doctors of medicine; and limited the use of human x-ray to that actually performed by or

under the supervision of physicians, osteopaths, podiatrists and dentists. An intensive campaign was conducted by several KMA committees and the Woman's Auxiliary to KMA. Although the KMA-sponsored bills were not passed, our State legislators were provided with educational material and are much better informed on this important subject.

The KMA Committee on Cults urges active participation by all Kentucky physicians in continuing educational efforts with legislators and the general public if we are to achieve our legislative goals.

The committee plans to have an exhibit at the Convention Center during the 1970 KMA Annual Meeting staffed by the members of the committee for the purpose of stimulating the interest of other physicians in the elimination of medical quackery.

Members of the Committee on Cults are most cognizant of their responsibility to the Association and the public. There is no doubt that medical quackery represents a tremendous loss to our economy, in addition to the health hazards it imposes on the public.

David B. Stevens, M.D., Chairman

Recommendations, Reference Committee No. 3

We have reviewed the Report of the Committee on Cults. The reference committee wishes to compliment Doctor Stevens and his committee for the work they have performed in the past year.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Ad Hoc Committee on Occupational Pulmonary Disease

The Occupational Pulmonary Disease Committee met twice during the Associational year, December 11, 1969, and April 29, 1970. At the December meeting a series of recommendations for proposed legislation were formulated and presented to the Chairman for State Affairs, KMA Committee on Legislative Activities. A number of these were subsequently written into legislation that was passed during the 1970 Kentucky General Assembly. The meeting on April 29 was held primarily to discuss the fact that the Kentucky Department of Health had requested from the private sector a considerable amount of assistance in providing approximately 10,000 x-rays on coal miners who had filed for disability under the existing Workmen's Compensation Law and the Federal Coal Mine Safety Act. As a result of this meeting, the committee, speaking on behalf of KMA, offered the services of physicians in the areas most affected to provide these x-ray services.

Recommendations, Reference Committee No. 3

The Report of the Occupational Pulmonary Disease Committee was studied. We extend our appreciation to this committee for its important work in this field.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Ad Hoc Chiropractic Committee

The Ad Hoc Chiropractic Committee was formed late in June and held its first meeting on July 7. Specific proposals were made by the committee regarding legislation, committee membership, and dissemination of information.

Recommendations, Reference Committee No. 3

The report of the Ad Hoc Chiropractic Committee was reviewed. We wish to thank the members of this committee for their fine contributions.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 3 as a whole.

(Motion was seconded and carried.)

Mr. Speaker, as chairman, I wish to thank the members of this committee for their help in preparing this report and also a note of thanks to our secretary, Miss Patricia Borders.

REFERENCE COMMITTEE NO. 3

Cecil L. Grumbles, M.D., Louisville, Chairman
Carl J. Brueggemann, M.D., Covington
Jerry D. Fraim, M.D., Paintsville
John P. Hill, Jr., M.D., Somerset
John S. Oldham, M.D., Owensboro

At this time, Doctor Greathouse introduced Kenneth C. Peters, M.D., Chairman of the KEMPAC Board of Directors, who presented his annual report concerning KEMPAC activities to the members of the House. Doctor Peters concluded his report with the following statement: "The 1969 KMA House of Delegates as in previous sessions reaffirmed its belief in the objectives of KEMPAC and AMPAC and recommended 100% participation by doctors and their wives. It further recommended reaffirmation of KMA policy, that there be county society billing in order to encourage this participation, and recommended a vote of endorsement and encouragement of the KEMPAC organization to continue its worthwhile political efforts on the behalf of our free enterprise system and the freedom of the art and science of medicine. We are most appreciative of the action taken by this House in the past and request your continued encouragement and endorsement.

Dr. Greathouse thanked Dr. Peters for his report.

REFERENCE COMMITTEE NO. 4

Thomas L. Heavern, M.D.,
Highland Heights, Chairman

Reference Committee No. 4 considered the following reports:
13. Report of the Board of Directors, Kentucky Physicians Mutual, Inc.
21. Report of the Advisory Committee to Blue Shield
22. Report of the Advisory Committee to Blue Cross
33. Report of the Committee on Community and Rural Health
34. Report of the Committee on Air and Water Pollution
36. Report of the Senior Day Committee
37. Report of the Committee on School Health, Physical Education and Medical Aspects of Sports
Resolution C—The Report of the Surgeon General's Advisory Committee on Smoking and Health (Fayette County)

Resolution G—Amphetamines (Richard B. McElvein, M.D., Fayette County)
Resolution H—Blue Shield Claim Forms (Warren-Edmonson-Butler Counties)
Resolution J—Approval of Family Planning (Jefferson County)

Report of the Board of Directors Kentucky Physicians Mutual

The past twelve months have been very challenging to not only health care providers but Blue Shield as well. Never before has there been as much criticism, public concern, press coverage and general questioning of the health care system, including voluntary prepayment organizations. In the face of so much public adversity, it is a pleasure for me, as Chairman of the Board of Kentucky Physicians Mutual, to bring you this positive report of accomplishments.

Kentucky Blue Shield's membership is now in excess of 1,065,000, which is a net gain of 4.5% in the last twelve months. There are over 450,000 members now with protection to help pay for long-term or catastrophic illness, in addition to basic protection. In the same period, over 1200 additional companies voluntarily enrolled their employees and dependents in Blue Shield, making a total of 11,750 companies now enrolled. In October of 1969, the Motors industry added a program for prescription drugs, and there are 24,575 Kentucky Blue Shield members with this new special contract. Over 57,000 people 65 years of age and over are enrolled in the "over 65 program" to help fill the voids in Medicare. In the last twelve months, we have paid in excess of $16,243,000 for services to members, which is an increase of $3½ million over our last report. Total payment for services rendered our members since the organization of Blue Shield is now over $120,000,000.

Our Kentucky Blue Shield Plan is sound financially and has reserves of $10.91 per member. We continue to operate with one of the lowest overhead costs per member of the 74 Blue Shield Plans in America. Of the Plans with more than a million members, we rank first in low cost of operation per member.

In the past year we formed, on a statewide basis, a distinguished Consumer Advisory Committee to Blue Shield. Because of the universal concern over health care cost and delivery and this committee's sincere desire to be helpful and to delve into problems and issues, the committee has now been expanded and will also serve in an advisory capacity to Kentucky Blue Cross. The committee is concerned with providing a voluntary financing mechanism for necessary services provided on a basis other than traditional acute care, such as home health care and nursing home care. An endorsement to Blue Cross and Blue Shield certificates is now being drafted and rated for sale to members to pay for services provided members in approved extended care facilities. We are hopeful that a high percentage of our members are willing to pay the additional dues necessary to provide such protection.

The past eighteen months have seen the dramatic support of the Usual, Customary and Reasonable Blue Shield Program by Kentucky physicians. Currently 76% of Kentucky physicians have signed a Participating Agreement and the percentage continues to rise each month. During this eighteen-month period, 125,846 Usual and Customary claims have been processed representing a total payment of $7,006,388 for members' services under the program. The Board of Directors and staff are highly complimentary of the local review committees, the central review committee, and the Kentucky Medical Association Claims and Utilization Review Committee, and are appreciative of their dedicated work and long hours. In 1969, only 173 cases were referred to a committee and this case figure represented .0022 of the total claims submitted. In the first six months of 1970, forty-five cases were referred to a review committee, representing .0009 of the total cases. The Usual, Customary and Reasonable Program is working and helping Kentuckians voluntarily prepay the cost of necessary professional care. We appreciate the help of many Kentucky doctors who recognize the importance of making such programs work.

The Kentucky Medical Association started Blue Shield for the people to help solve a socioeconomic problem, to help people voluntarily budget for health care and to be in a better position to meet their financial responsibility to their doctors. There were other objectives, also, to try to help prevent the socialization of medicine and further government encroachment, to strengthen the voluntary free enterprise system. This is a never-ending fight and today we are still very much in the forefront. The furore over Medicare, Medicaid, the cost of care, the accessibility of care, has increased possibilities that efforts will again be attempted in Congress to establish a compulsory federal health program. We

think strong, successful, voluntary prepayment organizations such as Kentucky Blue Shield are one of the first lines of defense against complete compulsory government health schemes.

We need the understanding and support of the doctors of Kentucky as well as that of business, industry, labor, and the general public in our efforts. These are very crucial times. It is vital that Blue Shield work to the satisfaction of not only the doctors of Kentucky but to members and the public at large.

Our voluntary system for prepayment is strong; it is vital; it is growing. We have many dedicated people in and out of medicine who give of their time to make it work. We are extremely grateful to all of them. We know that what we are doing and that our objectives are in the best interest of the people, the medical profession and our voluntary system. We wish to extend to the members of the entire medical profession of Kentucky and to the staff of the Kentucky Medical Association our sincere thanks for their cooperation and contribution in helping make this another successful year.

Garnett J. Sweeney, M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Board of Directors, Kentucky Physicians Mutual, Inc. was reviewed, and a letter of correction from Mr. Avil McKinney of the Kentucky Physicians Mutual, Inc. was received correcting paragraph 5, line 17, of the report to read:

"In the first six months of 1970, 57 cases were referred to a review committee, representing .0012 of the total cases."

The committee was pleased to learn of the increased services rendered by Blue Shield and the continued low overhead. We compliment Doctor Sweeney for his complete report on the year's operations.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Advisory Committee to Blue Shield

The KMA Advisory Committee to Blue Shield met on June 4, 1970. The meeting was both productive and informative.

The 1969 Report to the House of Delegates was reviewed and careful attention was given to the Usual, Customary and Reasonable Blue Shield Program as reaffirmed by the House of Delegates last year. Special emphasis was taken in reviewing the operation of the program this year.

We were pleased to have members of the Blue Shield staff in attendance to include the President of Blue Shield, Mr. J. Ed McConnell. A report on Enrollment noted that there were 951 new groups enrolled during 1969 for a 4.8% net increase in Blue Shield membership, and that Blue Shield exceeded 1,000,000 members for the first time during 1969. In addition to enrolling new Blue Shield membership, there has been a concerted and successful effort to upgrade the coverage of current members, and to bring about new benefits to holders of Blue Shield certificates. Some new benefits recently added, or in the process of development, are Renal Dialysis, Extended Care Facility coverage, a dental plan, and a number of diagnostic procedures. Others include a study toward developing coverage for Home Health Care services.

Your Advisory Committee feels that the Blue Shield Professional Relations staff provides a valuable service not only to the Blue Shield subscribers, but especially to our own physicians. In 1969, we were impressed that the staff had made over 2,900 physician office and clinic visits and had met wth over 100 county medical societies, medical staffs and utilization review committees. Personal contact with some 800 physicians was made by the staff during the first quarter of 1970. Eighteen seminars for physicians' assistants were conducted by Blue Shield, and 1,306 of our medical assistants attended these seminars.

As indicated earlier in the report, your committee directed its attention to the UCR Program as we acknowledge our responsibility to report on its status to the House of Delegates. In 1969, there were 78,-461 cases processed under the Usual, Customary and Reasonable Program by Blue Shield, of which 173 cases were referred to Peer Review Committees. This means that of the claims submitted under the UCR Program, only .0022% (.0022 of one percent) had to be referred for Peer Review.

At the end of the calendar year 1969, there were 15 county society review committees established in addition to the state-wide review committee. Nine of these committees were utilized in reviewing the 173 cases.

During the first quarter of 1970, 19,739 claims were processed of which 13 were sent to Peer Review for a percentage of .00065%. In addition, seven additional counties established Peer Review Committees.

Over 75% of the eligible physicians in the state have signed Participating Agreements for the UCR Program, and we were especially pleased to note that there are 56 counties with 100% participation. Your committee reiterates that it feels that it is in the best interest of the individual physician and the profession for physicians to participate fully in the program and we feel confident that we will approach the 100% mark as more members receive more knowledge about the program. We urge your participation.

The members of the committee felt that it might be of interest to the delegates and other members of KMA to have available for review a status report on a county-by-county basis of the percentage of physicians participating in the program. This record is as of June 1, 1970, and is located at the end of this report.

The KMA Claims and Utilization Review Committee Chairman was in attendance and reported on the activities of his committee. We were pleased to note the dedicated and effective work of the committee and its chairman. We feel that Kentucky is fortunate to have had such a group to devote so much time in order to create the respected peer review mechanism which we have in our state.

Your committee discussed in some detail the increasing role of government in medicine and how the voluntary system must react in order to maintain the private practice of medicine. The President of Blue Shield discussed legislation that is being introduced across the country (and already passed in some states) that would certainly be detrimental to the voluntary health care system. In addition. your committee members reviewed national legislative matters involving compulsory universal health insurance and the numerous plans already proposed. Certainly it is the age of the consumer and current trends must be carefully watched.

Your committee feels that it is imperative that those in the free enterprise system use their initiative in developing programs through which private practice can be maintained and government medicine kept to a minimum.

We recognize that forces are in existence to cause experimentation with various methods of delivery of health services. We believe that if such experimentation is conducted, approved by the appropriate county medical society and the Kentucky Medical Association, that the Kentucky Blue Shield Plan be requested to work in cooperation with KMA in developing an appropriate prepayment mechanism for such experimentation.

The Blue Shield staff reported in some detail on a new Insurance Code passed by the 1970 General Assembly. We were pleased to note that there were no significant changes in the laws under which Kentucky Blue Shield operates. Blue Cross of Kentucky is incorporated under a special act called Non-profit Hospital, Medical, Surgical, Dental and Health Services Corporations. There were some revisions in this law which had not been changed since 1938. They dealt with investments, increases in fees for legal filings and a revision which permits any corporation under this act to pay for benefits provided by any health care provider. A premium tax had been proposed on all Kentucky Blue Cross subscribers' dues, but was not adopted. Instead, the new Code places a fee of 2¢ per contract in force per annum on Blue Cross dues which is to be used to defray administrative costs by the Department of Insurance.

It is your committee's responsibility to make recommendations through the Board of Trustees to the Blue Shield Board of Directors on all policy matters of mutual interest and to help promote improvement and extension of coverage offered to the public in the field of voluntary health care and attempt to assist in the solution of such problems.

The members of this committee have again demonstrated their dedication to duty and the chairman is indebted to them for their time and efforts, and is also appreciative of the counsel of the Blue Shield staff.

Kenneth P. Crawford, M.D., Chairman

COUNTY	NO. OF ELIGIBLE DOCTORS	NUMBER SIGNED	PERCENTAGE OF PARTICIPATION
Adair	5	5	100
Allen	5	0	0
Anderson	4	4	100
Ballard	3	1	33
Barren	20	18	90
Bath	3	3	100
Bell	27	25	92
Boone	14	13	92
Bourbon	11	1	9
Boyd	51	45	88
Boyle	20	19	95
Bracken	3	2	66
Breathitt	2	0	0
Breckinridge	4	4	100
Bullitt	5	5	100
Butler	2	1	50
Caldwell	6	5	83
Calloway	18	15	83
Campbell	56	22	37
Carlisle	2	2	100
Carroll	6	5	83
Carter	2	2	100
Casey	4	3	75
Christian	37	34	92
Clark	12	7	58
Clay	4	1	20
Clinton	2	2	100
Crittenden	2	2	100
Cumberland	2	2	100
Daviess	65	47	72
Edmonson	2	0	0
Elliott	1	1	100
Estill	3	1	33
Fayette	369	189	50
Fleming	3	3	100
Floyd	20	20	100

COUNTY	NO. OF ELIGIBLE DOCTORS	NUMBER SIGNED	PERCENTAGE OF PARTICIPATION
Franklin	27	19	70
Fulton	7	7	100
Gallatin	1	1	100
Garrard	2	2	100
Grant	5	5	100
Graves	16	16	100
Grayson	7	4	57
Green	7	5	62
Greenup	8	7	87
Hancock	2	2	100
Hardin	27	23	85
Harlan	41	31	75
Harrison	9	5	55
Hart	6	4	66
Henderson	32	24	75
Henry	3	3	100
Hickman	2	2	100
Hopkins	47	46	97
Jackson	1	1	100
Jefferson	775	676	87
Jessamine	5	1	20
Johnson	11	11	100
Kenton	104	45	43
Knott	2	2	100
Knox	7	6	85
Larue	3	3	100
Laurel	8	8	100
Lawrence	9	8	88
Lee	2	2	100
Leslie	3	3	100
Letcher	17	15	88
Lewis	2	2	100
Lincoln	3	3	100
Livingston	3	3	100
Logan	13	5	38
Lyon	2	2	100
McCracken	66	60	90
McCreary	2	2	100
McLean	4	3	75
Madison	22	14	63
Magoffin	2	0	0
Marion	9	8	88
Marshall	9	9	100
Martin	3	3	100
Mason	14	11	71
Meade	2	2	100
Menifee	2	2	100
Mercer	9	7	77
Metcalfe	2	2	100
Monroe	7	5	71
Montgomery	10	7	70
Morgan	3	3	100
Muhlenberg	12	11	91
Nelson	8	8	100
Nicholas	3	3	100
Ohio	10	6	60
Oldham	8	8	100
Owen	2	2	100
Owsley	0	0	0
Pendleton	4	3	75
Perry	17	17	100
Pike	27	19	78
Powell	2	1	50
Pulaski	22	20	90
Robertson	1	1	100
Rockcastle	2	2	100
Rowan	11	5	45
Russell	3	2	66
Scott	7	5	71
Shelby	6	6	100
Simpson	7	7	100
Spencer	2	2	100
Taylor	7	7	100
Todd	4	4	100
Trigg	5	2	40

COUNTY	NO. OF ELIGIBLE DOCTORS	NUMBER SIGNED	PERCENTAGE OF PARTICIPATION
Trimble	2	2	100
Union	4	2	50
Warren	53	7	13
Washington	4	4	100
Wayne	5	5	100
Webster	4	3	75
Whitley	13	13	100
Wolfe	1	1	100
Woodford	8	8	100
TOTALS	2444	1835	75

There are a total of 56 counties with 100% participation.

Recommendations, Reference Committee No. 4

The Report of the Advisory Committee to Blue Shield was read. A correction in paragraph 5, line 9, was noted. The correct review figure is 0.22 of one percent. The Chairman of the Advisory Committee to Blue Shield appeared before the Reference Committee and presented an informative discussion of the plans and development of Blue Shield during the past year. The committee commends Doctor Crawford on this fine work and thanks him for the time he gave in appearing before this committee.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Advisory Committee To Blue Cross

The Medical Advisory Committee to Blue Cross is composed of sixteen physicians which are appointed from various areas in Kentucky. Members of this committee meet at the Headquarters Office of Blue Cross and Blue Shield in Louisville to review questionable or controversial claims submitted by physicians that deal with the need and/or duration of hospital care.

During the eleven months beginning April 1, 1969, through March 1, 1970, the committee met three times and reviewed 25 cases, amounting to 871 hospital days. Of this amount, 184 days were disallowed. It is interesting to note that during the same period, 105 cases were reviewed by local review committees, amounting to a total of 1,618 hospital days, of which four were disallowed.

By continuously monitoring the Blue Cross Plan, the committee serves the dual purpose of furnishing the public and medical profession with the most advantageous coverage possible for the premiums paid, while at the same time, avoiding abuses to Blue Cross by studying and correcting trends before they become abuses and striving to keep the physicians in the state informed and interested in the operation of Blue Cross.

The members of this committee are to be congratulated for their assiduity, dedication, and loyalty. Not only is their work educational to the other physicians in the state, but by accepting the responsibility of this committee's work, they demonstrate that the Kentucky Medical Association and Blue Cross are making an honest effort to screen hospitalizations and to prevent unnecessary or prolonged hospital stays by patients.

Our entire committee usually meets once a year in conjunction with representatives from Blue Cross to discuss the work of the committee, and to make constructive recommendations to Blue Cross.

George W. Pedigo, M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Advisory Committee to Blue Cross points out the continued efficient operation of this organization. The committee feels that great caution is indicated in comparing utilization figures at the local and state level. Great care should be exercised to be sure that compared cases are equivalent situations.

We wish to thank Doctor Pedigo and his committee for his informative report.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Community and Rural Health Committee

Your Community and Rural Health Committee met at the Headquarters Office on March 26, 1970. The initial part of the meeting was devoted to a review of the past activities of the committee which include the responsibility of continually investigating means for improving all aspects of public and mental health in Kentucky, studying all aspects of TB and TB control, and as an objective, the decreasing of deaths and disabilities caused by motor vehicles.

In the past, the committee has promoted the first week in May as Immunization Week in Kentucky. This year, the committee expanded its focus to the promotion of Community Health Week which emphasized the benefits of physical fitness, particularly to adults. The committee would like to express its appreciation for the cooperation of the membership in this program. In addition, we received considerable assistance from numerous allied organizations, for which we are grateful. Hopefully, the future promotion of Community Health Week will emphasize local medical progress, available health services and facilities, and the individual and cooperative roles played by members of the community health team.

In the area of rural health, the committee has taken steps to encourage the participation of the KMA membership in Home Health Care Programs and will continue to do so. This year we wrote

each physician member and each Regional Comprehensive Health Planning Council explaining the concept of Home Health Care and urging its consideration as a priority item by each planning council.

Our committee continues to maintain liaison with representatives and agencies that have similar interests in the areas of responsibility assigned to us. This year, Dale H. Farabee, M.D., Commissioner of Mental Health, was invited to our meeting to discuss the current status of mental health, drug abuse and alcoholism in the Commonwealth.

It has been brought to the committee's attention that many of Kentucky's statutes concerning reportable diseases are now outdated and in need of revision. These statutes are currently under study by the committee and we hope to make some recommendations as to how they might be revised prior to the 1972 Kentucky General Assembly.

Highway safety continued to be of major interest to us. The committee has established a Safety Award of the Kentucky Medical Association which can be given to any group or individual who makes an outstanding contribution in the area of public safety. In addition, we continue to promote the KMA Automotive Safety Award which has now been presented to a number of organizations who have agreed, or have required their employees, to wear seat belts any time they drive a motor vehicle.

Because of our varied duties, the Community and Rural Health Committee is composed primarily of physicians who have chaired KMA committees in the past on the specific subject areas which have been assigned to us; that is, mental health, public health, tuberculosis and highway safety. I am deeply indebted to these committee members for their participation and leadership in their areas of responsibility this past year.

John M. Baird, M.D., Chairman

Report To The KMA Committee On Community And Rural Health

At the direction of the Chairman of the KMA Committee on Community and Rural Health, a subcommittee of three, Adam Miller, M.D., Jesse W. Tapp, M.D., and Thomas Wallace, M.D., was formed to review the question of the present statutes on the reporting of communicable diseases. The subcommittee has considered the present situation, particularly as summarized in the current booklet, *Kentucky Communicable Disease Regulations,* and as stated in the Kentucky Revised Statutes. It is the concensus of the committee that the present situation is unrealistic and detrimental in the requirement that all communicable diseases be reported by the physician (page 3, *Kentucky Communicable Disease Regulations).* On the other hand, it is felt that appropriate reporting or other methods of determining the pattern of disease in the state is essential. Therefore, it is the sense of the subcommittee that the KMA Committee on Community and Rural Health recommend that an Ad Hoc Working Group be constituted by the KMA, the State Health Department, and any other interested parties to develop a major revision in the concept and practice of disease surveillance in the community. We feel that this subject is of sufficient importance to warrant an officially appointed and mandated study group representing the formal commitment of the respective organizations to this reform.

(This report was approved by the Chairman of the Community and Rural Health Committee prior to its being sent to the KMA House of Delegates.

Adam Miller, M.D.
Jesse W. Tapp, M.D.
Thomas S. Wallace, M.D.

Recommendations, Reference Committee No. 4

The Report of the Committee on Community and Rural Health was reviewed, discussed and approved. The committee takes particular note of a recommendation of a subcommittee studying communicable diseases regulations. This subcommittee recommends appointment of an ad hoc working group to review this matter. The Reference Committee feels that this is an important move. We thank Doctor Baird and the members of his committee for their hard work.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Report of the Committee On Air And Water Pollution

The Committee on Air and Water Pollution of the Kentucky Medical Association was appointed on November 24, 1969. This Committee is composed of Theodore T. Myre, M.D., Harvey Sloane, M.D., J. M. Trevey, M.D., C. Milton Young III, M.D., William Yates, M.D., and B. Frank Radmacher, Jr., M.D., Chairman.

The Air Pollution Control Commission of Kentucky met in early December to establish the standards for the state. Your committee had not been able to have a meeting prior to the hearing. In essence, the State accepted standards as follows:

Particulates—65 ug/M^3

Carbon Monoxide and Total Oxidants—the levels have been lowered to bring them into compliance with recently released Federal Criteria.

Sulfur Dioxide—Annual geometric mean—.02 ppm

Obviously, because of the time element, your committee had no opportunity to study these proposals before they were adopted.

In early January I met with Doctors Milton Young and Harvey Sloane, both of whom are knowledgeable in Air Pollution control and consulted with them concerning points we should stress in this committee. It was brought out in this meeting that there would be some areas of the state, such as Jefferson County, adopting standards either in line

with State standards or possibly more stringent than State standards. It was decided that this committee should have the following goals.

1. To make doctors in Kentucky aware of the contribution of air pollution to disease.
2. To help make doctors in Kentucky knowledgeable in standards concerning air pollution and to be available for testimony concerning air pollution and its relation to disease.
3. To stress the need for a group of speakers to be available for organizations desiring programs on this and related subjects.
4. To be able to advise on research projects concerning pollution, and we stress the need for a full time industrial engineer to supervise air sampling, reporting studies of other standards, etc.

Doctors Young and Sloane cited numerous examples of things that could be done to reduce air pollution such as staggering times of discharge from work to avoid traffic congestion in any particular areas at peak traffic times. They also pointed out that under certain climatic conditions industries could be notified to suspend operations and thus reduce SO_2 concentration.

A meeting was called on February 25th, but only Doctor Yates was able to attend, and we went over these issues as listed. We also discussed the possibility of having an article in *The Kentucky Medical Association Journal* and of putting small articles in the "KMA Communicator."

In June I polled the committee by telephone, and after obtaining a majority vote, went before the Jefferson County Air Pollution Control Committee asking for slightly more stringent standards than those outlined by the State.

Our next meeting was July 9th, with Mr. Ralph Pickard, the Executive Director of the Kentucky Water Pollution Control Commission. Mr. Pickard spent three hours outlining what his Commission was doing and this was a very informative and pertinent discussion. It is regrettable that none of my committee members were able to attend. We did have some interested members from the Jefferson County Medical Society.

In summary, this committee has not been a very active committee. It was the first year for the committee and undoubtedly needed this time to get the necessary background in order to function properly. It is my feeling that this committee in the future could and should be very active, and one which could bring to light many of the medical problems that confront the Kentucky Medical Association. I feel that it is only through such committee work that the Kentucky Medical Association will become involved in the ecology of Kentucky.

I would advise that in the future the committee should be enlarged, drawing representatives from all areas of the state: from the southeastern area, the Ashland area, the Newport-Covington area, the Owensboro area, the Paducah area, and Lexington, Frankfort and Louisville areas.

B. Frank Radmacher, Jr., M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Committee on Air and Water Pollution indicates a considerable amount of effort expended by its Chairman, Doctor Radmacher, in initial efforts in this important and complex field. The committee commends him for his efforts, and agrees that his committee should be expanded as indicated in his report.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Report of the Senior Day Committee

Your Senior Day Committee met on November 20 to plan this year's Senior Day Program. As the program was redesigned last year, the committee followed the format from last year which brought the senior medical students from the University of Louisville and University of Kentucky together in a joint session. This year's meeting was held in Lexington and plans call for next year's session to be held in Louisville.

This year's program included an afternoon session which featured short presentations on "Features of Organized Medicine," "Medical Ethics and Courtesies," "Medical Records and Malpractice" and "Health Care Delivery." Following these presentations, the seniors were divided into four discussion groups with the guest speakers rotating to each group at 25-minute intervals.

The evening session of the program featured Russell B. Roth, M.D., Erie, Pennsylvania, Speaker of the AMA House of Delegates. The Fayette County Medical Society hosted the evening session and attendance this year was outstanding.

It is hoped that these programs will be of some help to the seniors and will serve as an influence to keep them interested and responsive to correspondence, programs and other informational services always readily available from the county, state and national medical groups. As in the past, kits of materials were distributed to each student to help narrow the communications gap that is becoming increasingly more evident.

We strongly encourage the continuation of this program with the usual full planning sessions as held in the past. In addition, the committee has requested that the Nominating Committee consider the addition to the committee of a student member from each medical school to aid in the planning of next year's program.

The committee is grateful to KMA, the House of Delegates and the Board of Trustees for their help in making it possible for us to serve in this capacity. Appreciation is also extended to the KMA members and guests who participated, the University of Kentucky College of Medicine, the University of Louisville School of Medicine and the Fayette and Jefferson County Medical Societies. As Chairman, I would also like to thank the members of the committee, Eugene Conner, M.D., Louisville; Walter I. Hume,

Jr., M.D., Louisville; Ji-toong Ling, M.D., Louisville; Richard B. McElvein, M.D., Lexington; and Myron G. Sandifer, M.D., Lexington, for their excellent cooperation in the preparation of this program.

Hoyt D. Gardner, M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Senior Day Committee was examined closely. The reference committee heard lengthy testimony concerning the problems involved in presenting a worthwhile program for the medical school seniors.

Doctor Gardner has wisely suggested the addition of student members from each medical school to his committee. We agree that the Board should make such appointments. With this addition, hopefully, continued revision and reappraisal of the need for this program and study of alternative methods of achieving the goals of this committee can be accomplished.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Report of the Committee on School Health, Physical Education and Medical Aspects of Sports

The School Health, Physical Education and Medical Aspects of Sports Committee has had two meetings this year and plans to hold one more late in the summer.

Our last meeting will be to plan medical aspects of sports seminars to be held in conjunction with the high school football rules conferences which are given throughout the state immediately preceding the start of the football season. Members of the committee coordinated several of these seminars last year and were pleased with the response of both coaches and physicians to them.

We continue our strong interest in seeing school health committees activated at the county society level. A number of these committees have been organized and we urge all county societies to appoint such committees next year. Our committee has developed a set of guidelines to aid each local committee in establishing a sound school health program in their community. Hopefully, this will also create a stronger liaison with our own committee at the state level.

This year, as in the past, we were privileged to have the opportunity to present an exhibit at the Annual Meeting of the Kentucky Education Association in Louisville. Our exhibit was entitled "Health Appraisal of the School Child" and we were pleased with the interest shown in it by the educators.

The committee is interested in seeing the standardization of College Health Record Forms. The AMA and the American College Health Association have devised a standardized form which we have endorsed and plan to send to Kentucky's colleges and universities urging its implementation.

We are also continuing our liaison with the Kentucky Department of Education and other statewide groups that have a particular interest in the health of our school age children.

The committeee now has representatives from each of KMA's fifteen Trustee Districts and the members have expressed a keen interest in the work and goals of this committee and have demonstrated a desire and willingness to work toward the attainment of those goals. I, as Chairman, would like to commend them for their efforts.

O. B. Murphy, M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Committee on School Health, Physical Education and Medical Aspects of Sports was reviewed and approved. Doctor Murphy is commended for his continued vigorous efforts in this important field.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Resolution C

Fayette County Medical Society

WHEREAS, "*The Report of the Surgeon General's Advisory Committee on Smoking and Health,* issued in 1964, concluded that cigarette smoking is causally related to lung cancer, that it is associated with heart disease, that it is the most important cause of chronic bronchitis, that it substantially increases the risk of premature death, that it is, in short, an important health hazard," and

WHEREAS, "These findings have been accepted by the major medical and scientific organizations of the world and now have been confirmed and strengthened by additional Public Health Service reviews of 1967 and 1968" and

WHEREAS, the following facts emerge from the Public Health Service reports of 1967 and 1968.

I. The risk of death is about 70 percent higher for men who smoke cigarettes than for men who do not. The risk is significantly higher, also, for women who smoke cigarettes than for those who do not.

II. The risk of death from lung cancer is up to 10 times greater for cigarette smokers than for nonsmokers.

III. The risk of death from chronic bronchitis and emphysema is between 3 and 20 times greater, depending upon age and total amount smoked.

IV. The risk of death from coronary artery disease—which is the major killer of smokers and nonsmokers alike—is 70 percent greater for smokers than nonsmokers.

V. Life expectancy amoung young men is reduced by an average of 8 years in heavy cigarette smokers —those who smoke over 2 packs a day—and an average of 4 years in light smokers—those who smoke less than 1/2 pack a day, and

WHEREAS, there are few smokers before the age of ten, exploratory smoking increases rapidly in junior high school and a lifetime habit often develops in high school, and

WHEREAS, those who begin smoking under age 21 smoke more cigarettes, inhale more, and run a far greater risk of illness, disability and loss of life than those who begin smoking later or who do not smoke, and

WHEREAS, the greatest opportunity to prevent the health hazards of cigarette smoking is thru education, therefore be it

RESOLVED, that the Kentucky Medical Association recognizes the deleterious effect on human health of cigarette smoking and, therefore, actively endorses and supports efforts by young people, by

parents, teachers, voluntary health agencies, and especially physicians in the educational effort to protect youth in particular and the population in general from the health hazards of cigarette smoking, and be it further

RESOLVED, that copies of this resolution be sent to the Governor of the State of Kentucky, Chairman of the State Board of Health, State Superintendent of Public Instruction, and news media.

Recommendations, Reference Committee No. 4

Resolution C, The Report of the Surgeon General's Advisory Committee on Smoking and Health, introduced by Fayette County, was carefully considered. Much supporting evidence for the resolution was heard, and no opposition was voiced. The committee feels that this resolution provides a good, factual exposition of the problem, and recommends the adoption of this resolution.

Mr. Speaker, I move the adoption of this section of the report.
(Motion was seconded.)

There was considerable discussion concerning this resolution. Following complete discussion, a motion was made and seconded to table the above motion. This motion to table was carried by a 55 to 38 margin.

Resolution G

Richard B. McElvein, M.D. (Fayette County)

WHEREAS, amphetamines are a part of the national drug abuse in this country, and

WHEREAS, prescribed amphetamines are diverted to illicit use, and

WHEREAS, in the best medical judgment amphetamines have limited medical application, therefore be it

RESOLVED, that the members of the Kentucky Medical Association voluntarily agree not to write prescriptions for amphetamines and products containing amphetamines, unless specifically indicated, to reduce the exposure of the public to these dangerous drugs.

Recommendations, Reference Committee No. 4

Resolution G, concerning Amphetamines, introduced by Richard B. McElvein, M.D. of the Fayette County Medical Society, was considered. Doctor McElvein appeared before the committee to discuss the resolution, and an informative discussion of the problem of drug abuse was heard. The committee feels that the resolution as presented should be rejected and the following resolution substituted:

"WHEREAS, amphetamines are a part of the national drug abuse in this country, and

WHEREAS, prescribed amphetamines are diverted to illicit use, and

WHEREAS, in the best medical judgment amphetamines have limited medical application, therefore be it

RESOLVED, that the members of the Kentucky Medical Association reaffirm their belief that these dangerous drugs should be prescribed with utmost care only for very limited specific indications as outlined by the American Medical Association Council on Drugs and Therapeutics."

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Resolution H

Warren-Edmonson-Butler County Medical Society

WHEREAS, there is no place on the current Blue Shield claim forms for assignment of claim benefits to the physician, therefore be it

RESOLVED, that the Kentucky Medical Association House of Delegates request that Blue Shield provide a claim form with a blank on it to be filled in by the patient, assigning his claim to the physician.

Recommendations, Reference Committee No. 4

Resolution H, Blue Shield Claim Forms, was introduced by Warren-Edmonson-Butler County Medical Societies. This resolution was reviewed, and an explanation of the methods of handling assignments was explained to the committee by Mr. Avil McKinney, Vice-President of Kentucky Physicians Mutual, Inc. The committee feels that every physician has the privilege of appending an assignment form to the Blue Shield claim form if he wishes, and therefore recommends rejection of this resolution.

Mr. Speaker, I move the adoption of this section of the report.
(Motion was seconded and carried.)

Resolution J

Jefferson County Medical Society

WHEREAS, the Kentucky Medical Association has representation on the Family Planning Task Force of the Human Resources Coordinating Commission of the State Government, and

WHEREAS, the physician members of the Kentucky Medical Association are in sympathy with and supportive of the goals of family planning, therefore be it

RESOLVED, that the House of Delegates of the Kentucky Medical Association go on record as officially approving again the concept of family planning in this state.

Recommendations, Reference Committee No. 4

Resolution J, Approval of Family Planning, was introduced by Jefferson County Medical Society. This resolution reiterates and clarifies a previous position of the Kentucky Medical Association, and the Reference Committee recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report.
(Motion was seconded and carried.)

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 4 as a whole, with the exception of Resolution C which was tabled.
(Motion was seconded and carried.)

Mr. Speaker, I wish to thank Doctor Branham B. Baughman, Frankfort; Doctor W. Neville Caudill, Louisville; Doctor Hugh L. Houston, Murray; and Doctor Leslie W. Blakey, Lexington, for their dedicated help in the hearings and preparation of this report. I also wish to thank Mrs. Shirley Roessler for her assistance.

REFERENCE COMMITTEE NO. 4

Thomas L. Heavern, M.D., Highland Heights, Chairman
Branham B. Baughman, M.D., Frankfort
Leslie W. Blakey, M.D., Lexington
W. Neville Caudill, M.D., Louisville
Hugh L. Houston, M.D., Murray

REFERENCE COMMITTEE NO. 5

Glenn W. Bryant, M.D.,
Louisville, Chairman

Reference Committee No. 5 considered the following reports:

25. Report of the Advisory Committee to Selective Service
39. Report of the Coordinating Commission of Governmental Medical Services
40. Report of the Technical Advisory Committee on Physician Services (Title XIX)
41. Report of the Advisory Committee on Title XVIII
42. Report of the Claims and Utilization Review Committee
43. Report of the Committee on Appalachian and OEO Programs
5. Report of the Chairman, Board of Trustees, Comprehensive Health Planning Committee Report only

Resolution A—Kentucky Medical Assistance Program (Allen County)
Resolution B—Kentucky Medical Assistance Program (Campbell-Kenton Counties)
Resolution D—Peer Review (Campbell-Kenton Counties)
Resolution E—Compensation for Peer Review Activity (Campbell-Kenton Counties)
Resolution K—Medicaid (Jefferson County)
Resolution L—Medicare (Jefferson County)

Report of the Advisory Committee to Selective Service

The purpose of this committee is to maintain as far as possible an appropriate balance and distribution of medical personnel between our civilian population and the Armed Forces.

The committee has not met this year, and it appears that such a meeting may not be necessary.

Early this year, a letter from National Headquarters Selective Service System stated that due to the effectiveness of the Berry Plan as a major procurement source for medical officers, the Department of Defense could not foresee the need to request a special call for physicians to meet its medical corps officer requirements for the fiscal year 1971.

One case was considered by the committee this year. All members were polled by mail. A recommendation for one year deferment was made to the appropriate official in the Navy Department in Washington, D.C. A copy of this correspondence was sent to KMA Headquarters Office.

The committee members have been most prompt and cooperative. Excellent support has been given us by KMA Headquarters and State Selective Service Headquarters in Frankfort.

I will appear before the appropriate Reference Committee at the September meeting in order to give additional information if requested, and to answer any questions that may be asked.

Glenn U. Dorroh, M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 reviewed the Report of the Advisory Committee to Selective Service and heard a supplemental report given by Glenn U. Dorroh, M.D., Chairman of this committee. He explained the exact function of this committee and said the committee's relationship with the State Selective Service Headquarters and the National Selective Service Headquarters continued to be satisfactory.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Coordinating Commission on Governmental Medical Services

The Coordinating Commission on Governmental Medical Services met on June 17 to exchange information and discuss problems of mutual interest to the five committees represented on the Commission. These committees have held one or more meetings this year, and some of them have spent a great deal of time in reviewing the various programs administered by government agencies and private carriers.

The Committee on Appalachian and OEO Programs continues to keep abreast of the progress the Appalachian and OEO Programs are making in the delivery of health care. These programs seem to have adequate physician representation.

The Claims and Utilization Review Committee is to be congratulated on the organized approach it is taking to problems of peer review. This committee, in compliance with the request of the KMA Board of Trustees and the 1969 KMA House of Delegates, has accepted the additional responsibility of reviewing the utilization of services, as well as individual claims. The committee functions in this area as the review mechanism for both the Title XVIII (Medicare) and Title XIX (Medicaid) Programs, as well as reviewing cases submitted by private carriers.

The Committee on Medical Education continues to study and make recommendations on matters relating to the Ohio Valley Regional Medical Program as set forth by PL 89-239 (Heart, Cancer and Stroke). Two major areas of interest this year have been postgraduate medical education and the attitude of KMA members concerning the concept of the clinical associate or physician's assistant.

The Advisory Committee on Title XVIII requested the Claims and Utilization Review Committee to take over peer review functions for Medicare claims. The committee's primary function this year has been that of a liaison nature between KMA and the Medicare carrier.

The Technical Advisory Committee on Physician Services (Title XIX) requested that the Claims and Utilization Review Committee take over the peer review functions for Medicaid claims. This committee has again experienced many problems in serving

in an advisory capacity to the Advisory Council for Medical Assistance and has spent many hours in meetings with Frankfort officials to make recommendations for the improvement of the Medicaid Program in Kentucky.

All of the committees represented on this Commission are to be highly commended for their dedication and service to this Association.

Edward N. Maxwell, M.D., Chairman

Recommendations, Reference Committee No. 5

The reference committee has reviewed the Report of the Coordinating Commission on Governmental Medical Services. This report contained no recommendations.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Technical Advisory Committee on Physician Services (Title XIX)

The five-member, KMA-appointed Technical Advisory Committee on Physician Services (Title XIX) is a quasi-governmental body called for by the Kentucky Statutes. It is one of seven provider groups "established for the purpose of acting in an advisory capacity to the Advisory Council for Medical Assistance."

The committee met on five occasions during the Associational year. Three meetings were held prior to Advisory Council meetings which were also attended by committee members.

There are many unsolved problems in the operation of over $50 million annual program which includes approximately 10 percent of the State's population as eligible recipients. Early last fall, in a special meeting with the Advisory Council, the Governor expressed serious concern about the rising level of expenditure in the Kentucky Medicaid Program. He pointed out that unless ways are found to deal with the problem, the State would be unable to support the cost. Governor Nunn charged the Council to "devise new ways to improve the quality of medical services to welfare recipients. Utilization review, its structure and methods are all subjects of concern."

In response to the charge by the Governor, the Advisory Council for Medical Assistance has recommended a "Proposal for Systematic Surveillance of Program Effectiveness through Peer Review." This proposal deals with "organized surveillance of: (1) Utilization of services; (2) Standards of care; (3) Compliance with participation agreements and program regulations.

"This proposal calls for official action to establish under the Program a peer review structure paralleling the existing statutory technical advisory committees, with a peer review committee being designated for each of the major types of health services provided under the Program."

While the statutory technical advisory committees of the Council will be designated as peer review committees for most types of services, the KMA Technical Advisory Committee on Physician Services will use the established mechanism of local review committees and its KMA Claims and Utilization Review Committee to refer cases for appropriate study and recommendations.

Basic elements of surveillance recommended by the Council include a computer "profile" to be developed and maintained on each beneficiary using health services under the Program. Computer "screens" would be developed on norms relating to such factors as frequency, duration, amount and patterns of services. Deviations would be reviewed by staff and exceptions would be turned over to peer review committees.

Federal regulations require agreements with every person or institution providing services under the Medicaid Program. The original Physician's Application for Participation Agreement submitted to the committee incorporated features greatly exceeding the Federal requirements, and it was the recommendation of this committee that the participating agreement be confined to that required by Federal regulation. The letter, as mailed, was confined to the Federal requirements.

At the time this report was written and for many months, the Program has been without a medical director or regular physician consultants. This committee recommends the immediate employment of a full-time medical director or medical consultants to give guidance to the Program and to help implement an effective surveillance system.

The committee has continued to make a number of other recommendations, including payment of usual and customary physicians' fees for in-hospital services and the inclusion of glaucoma medications and liquid iron drops to the approved Medicaid drug list. Because of budgetary deficiencies, neither recommendation had been implemented at the time this report was written.

However, at the June 30, 1970, meeting of the Advisory Council for Medical Assistance, the Subcommittee on Formulary Drugs recommended the early implementation of the addition of liquid iron drops for children 10 years of age or under and anti-glaucoma medications.

As chairman, I wish to thank the dedicated members of this committee who have served so diligently in the interest of an improved Medicaid Program in Kentucky. The committee members were saddened by the loss of one of its dedicated members, Lawrence U. Gilliam, M.D., of Corbin, Kentucky, on February 25, 1970.

Thomson R. Bryant, Jr., M.D., Chairman

Recommendations, Reference Committee No. 5

The reference committee has reviewed the Report of the Technical Advisory Committee on Physician Services (Title XIX) and heard additional comments from the Chairman, Thomsom R. Bryant, Jr., M.D. Additional testimony was given by several delegates in attendance, as well as William P. McElwain, M.D., the new Commissioner of Health, and Emanuel

Rader, M.D. Many questions were answered by Doctors McElwain and Rader concerning physician services.

Reference is made to the fact that the committee has continued to recommend usual and customary payment of physicians' fees for in-hospital services, as well as out-patient services.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Advisory Committee on Title XVIII

This committee, in accordance with recommended policy, requested the Claims and Utilization Review Committee to take over the Peer Review functions arising out of Medicare claims which are contested. Transfer of this obligation leaves our committee with functions which are primarily of a liaison nature between KMA and the Medicare carriers.

The committee wishes to call to the attention of the KMA member that bills submitted on Medicare forms should reflect his usual and customary charge, regardless of the amount allowed for payment by Medicare and Medicaid. This is the only method by which information regarding changing customary charges can be compiled by the Medicare carrier in order that periodic changes in a physician's profile of charges can be made.

Because of the fact that there appears to be misunderstanding on the part of Title XIX carrier concerning the fact that Title XVIII carrier is requesting the usual and customary charge rather than an allowable fee, this committee has made the following recommendation to the Technical Advisory Committee on Physician Services (Title XIX) through the Board of Trustees, "That KMA request the Title XIX carrier to accept billing forms from physicians showing their usual and customary fee for a given service, paying the allowable amount if it is less than the fee submitted and that said carrier desist from returning such statement to the physician with the request that the correct allowable fee be shown as his charge."

It was reported to the committee by the Title XVIII carrier that as of July 1, 1970, new customary and prevailing fees will be in effect, these fees to be based on the physicians' usual and customary charges made during the year of 1969. This committee hopes that this adjustment will be made annually.

The continuing problems experienced by extended care facilities, particularly those physically related to hospitals, were noted. The low occupancy of these facilities appears to be due in part to the reluctance of physicians to transfer convalescent patients to these less expensive facilities because of the paper work involved and the uncertainty of approval for payment for E.C.F. confinement. Further use of these facilities by physicians in order to release needed acute care beds is recommended.

The committee notes reports indicating that over-utilization of patient visits in the office, home and nursing home, as well as the use of injectables, continues to be a problem but shows a definite improvement in comparison with the preceding year.

Edward N. Maxwell, M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 reviewed the Report of the Advisory Committee on Title XVIII. The committee wishes to call to the attention of KMA members that bills being submitted on Medicare forms should reflect usual and customary charges regardless of the amount allowed for payment by Medicare and Medicaid.

The necessary items for admission of patients to extended care facilities has greatly hampered this part of the program, and we recommend review and simplification of admission policies for these patients, both from the standpoint of the admitting physician and on behalf of the administrators of the extended care facilities. We recommend that the Advisory Committee on Title XVIII seek to implement these recommendations.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Claims and Utilization Review Committee

At the organizational meeting of October 30, 1969, the Claims Review Committee adopted the above name, Claims and Utilization Review Committee. At this meeting, the committee was asked by the KMA Advisory Committee on Title XVIII and the Technical Advisory Committee on Physician Services (Title XIX) to function as the review committee for each of their activities. This additional work was assumed without hesitation by the Claims and Utilization Review Committee.

The members reviewed the committee's previous suggestion that one-third of the members be replaced each year and that a new chairman and a vice-chairman be appointed each year. It is the feeling of the committee that this should conform to the generally accepted practice of KMA, and that appointments of the chairman and committee members be at the Board's discretion with recommendations being submitted by the Claims and Utilization Review Committee to the Board of Trustees. It is recognized that the Board of Trustees may desire that a chairman serve more than one year to accomplish the goals of the Association.

Sixty-three consultants to the 20-man committee have been appointed by the Board of Trustees. This provides for representation in each of the disciplines of medicine from every section of Kentucky.

Work is in progress for the establishment of at least one peer review committee in each KMA trustee district for the handling of local problems as they arise.

The committee is currently conducting a survey to determine guidelines for the majority of major medical diagnoses in an effort to establish a method for routine settlement of claims.

In compliance with the House of Delegates request, assigned members of the committee will review, at least annually, the Blue Shield physicians' fee guidelines to insure that such fees will remain current, consistent with usual, customary and reasonable.

The committee met in an organizational session on October 30, 1969, and in executive sessions in February, March, April, May and August of 1970, to review claims and utilization cases referrred from carriers and physicians. Sixty-four claims of nineteen physicians have been reviewed and eleven claims of one physician are undergoing further study.

This has been a busy Associational year, but a very rewarding one for the members of the committee.

The chairman would like to thank each and every member of the committee for his valuable time expended in this, one of the most important functions currently being conducted in organized medicine.

Marvin A. Bowers, Jr., M.D., Chairman

Recommendations, Reference Committee No. 5

The reference committee has reviewed the Report of the Claims and Utilization Review Committee and heard additional remarks by its Chairman, Marvin A. Bowers, Jr., M.D. Doctor Bowers pointed out that this committee has been functioning as peer review for Title XVIII and Title XIX as well as a general review for the state since October 30, 1969. During this time, there have been no claims submitted concerning Title XIX.

It is pointed out to the members of KMA that this committee also functions for their benefit, and Doctor Bowers encourages more utilization on the part of the members concerning their individual grievances pertaining to these claims.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Committee On Appalachian and OEO Programs

The Committee held two meetings during the year. During the first, a review of both the OEO and the Appalachian Programs indicated that these are proceeding with little or no change in program plans. Some of the Appalachian programs which have become operational and have been announced through the news service are the ambulance service, home health service, emergency communication system, and the mental health-mental retardation centers. The Committee notes that there is physician participation in all levels of these programs, but that these physicians serve on advisory and administrative councils as individuals rather than official representatives of the KMA. A number of these physicians are on our Committee and are able to give first-hand accounts of progress of the program.

Second meeting, Dale H. Farabee, M.D., Commissioner of Mental Health, attended to report on the cooperation of the Regional Comprehensive Mental Health-Mental Retardation Programs in the Appalachian area. One of the problems which he outlined was the difficulty in obtaining professional persons. One of the barriers to employing foreign trained physicians is the legal restrictions on obtaining licensure in Kentucky in contrast to surrounding states which makes recruitment a great deal more difficult. The Committee recommends further investigation by the Board of Trustees on this matter with the possibility of legislative changes in our licensure laws.

Frank M. Gaines, M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 has reviewed the Report of the Committee on Appalachian and OEO Programs.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Ad Hoc Committee on Comprehensive Health Planning

The Comprehensive Health Planning Committee noted that Governor Nunn, in the state of the State Report to the opening session of the General Assembly, was proud that Kentucky was the first state to be formally organized and functioning in Comprehensive Health Planning. The medical profession across the state is responsibly participating with the other health professions and with the fine consumer representatives, to plan a truly comprehensive program of health service for every Kentuckian.

On March 21, the General Assembly adopted a model Tuberculosis Control Statute, gathering together the diffuse tuberculosis control activities into one agency, with one authority and one responsibility. Regional Comprehensive Health Planning Councils are planning the integration of surplus tuberculosis facilities into the regional pattern of efficient health planning.

The CHP Chairman desired that I particularly commend your attention to the diligence of the Quick Action Committee of the Board and the Legislative Committee in guiding the Tuberculosis Control Act through the General Assembly. KMA muscle and skill were deployed to keep this model legislation intact, Doctor Brockman reported.

Recommendations, Reference Committee No. 5

The reference committee has reviewed the section of the Report of the Chairman, Board of Trustees, concerning the Comprehensive Health Planning Committee.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Resolution A

Allen County Medical Society

WHEREAS, the Kentucky Medical Assistance Program has been poorly administered since its inception, and

WHEREAS, the administrators of the KMAP have repeatedly given misleading information to the press; to wit: Information that usual and customary fees are paid to providers and information that providers of service are paid within thirty days of

filing for payment. When actually usual and customary fees are not paid to providers; many providers are never paid at all for services to eligible patients and most usual payment for services is paid only after approximately three to nine months from time of billing for service, and

WHEREAS, physician providers of service for KMAP patients have repeatedly been given adverse publicity in the press indicating that they are over utilizing the program, when actually the administrators of the program are at fault for unusually high administrative costs, poor screening of patients for eligibility and acutally admitting patients to the program who often have their own private insurance, are well able to pay their bills and are in no way needy or poverty stricken, and

WHEREAS, many frequent, and often conflicting regulations are issued by the KMAP administrators, and these are often changed by executive order rather than by legislative process, and

WHEREAS, the KMAP has required all physician participants to sign an agreement to abide by the rulings of Title XIX of the Social Security Act. The administrators of the KMAP have themselves, when requested to sign a reciprocal agreement to also abide by all State and Federal provisions of Title XIX, have not even shown the courtesy of a reply to the request, therefore be it

RESOLVED, that the House of Delegates of the Kentucky Medical Association hereby withdraws its approval of the Kentucky Medical Assistance Program, effective October 1, 1970, and be it further

RESOLVED, that the House of Delegates urge the members of KMA to continue rendering high quality care to all persons regardless of their ability to pay, and without bureaucratic, dictatorial and wasteful interference of governmental third parties.

Resolution B

Campbell-Kenton County Medical Society

WHEREAS, the Medicaid or State Medical Assistance Program has been in existence in Kentucky for several years, and the majority of Kentucky physicians have cooperated with the program, and

WHEREAS, despite repeated promises for usual and customary fees which have never been fulfilled, and

WHEREAS, there has been only token attempts and many broken promises to budget money to pay usual and customary fees for both inpatient and outpatient care, and

WHEREAS, it is the feeling of this Society that there has been a breach of good faith on the part of the State Medical Assistance Plan, therefore be it

RESOLVED, that the Kentucky Medical Association inform its membership of this lack of good faith and release them from their commitments to cooperate and participate in the State Medical Assistance Program, and be it further

RESOLVED, that the Kentucky Medical Association withdraw all Kentucky Medical Association committees to the Title XIX Program.

Resolution K

Jefferson County Medical Society

WHEREAS, the Kentucky Medical Assistance Program has failed to realistically provide for the medically indigent of this Commonwealth as intended by Congress or understood by the public, and

WHEREAS, the Kentucky Medical Association has since 1960 cooperated with all branches of state government including the Health Department and the Department of Economic Security in good faith providing leadership and untold hours, days and weeks of officers' and other physicians' time and professional talent in an effort to make the program work for the best interest of the people, and

WHEREAS, the program has been underfinanced, mismanaged and falsely presented to the public, it is time for the Kentucky Medical Association to inform the State Legislature, the Congress of the United States and the people of Kentucky about some of the important facts which have caused this impossible situation, and

WHEREAS, during the last fiscal year (June 1969-1970) 19,500 surgical operations were performed on hospitalized Medicaid patients. The Medical Assistance Program did not provide physicians with any compensation for the performance of surgical procedures on these nearly 20,000 patients. The only "in hospital" benefits paid physicians for Medicaid patients is a small consultation or attendance fee, and

WHEREAS, by the calculation of less than an average fee for each of these surgical Medicaid patients, it is immediately evident the physicians of Kentucky are subsidizing the Medicaid program an estimated two million dollars ($2,000,000) per year for surgical patients and similar sums for 18,000 hospitalized seriously ill patients not requiring surgery, and

WHEREAS, there are inequities in the program where physicians are expected to provide their "outpatient" professional services at far less than the usual, reasonable and customary fees charged by doctors in the community, and

WHEREAS, the most recent KMAP booklet entitled, "What It's All About," published by the Kentucky Department of Health in August, 1970, is misleading in those sections which discuss the benefits under the program or the benefits to physicians as providers, and

WHEREAS, compensation for "in-patient" hospital services available to physicians under the Medicaid program, with few exceptions, requires that the physician accept a fee less than that provided by the average standard health insurance policy; and further no other provider of health services has been expected to continue to provide services without just compensation, and

WHEREAS, the program further leads the public to believe that doctors are paid adequately for all services, and

WHEREAS, we believe few, if any, other providers of service paid for by the government through taxes, receive equally shabby or discriminatory treatment, therefore be it

RESOLVED, that this resolution, along with accompanying additional information, be provided to the Congressmen and Senators from Kentucky as well as the Governor and responsible officers in the Commonwealth, requesting that the facts regarding Medicaid be made known to the public so that they may understand why physicians find it economically difficult to continue seeing and caring for patients under the Medicaid Program, and be it further

RESOLVED, a copy of this resolution together with additional information be provided to the news media in order that the public may be better informed regarding the fact that, in the future, physicians may prefer to see indigent patients in the manner of honored tradition rather than to accept the false premise and conduct of Medicaid.

Recommendations, Reference Committee No. 5

The reference committee has reviewed Resolution A—Kentucky Medical Assistance Program (Allen County), Resolution B—Kentucky Medical Assistance Program (Campbell-Kenton Counties), and Resolution K—Medicaid (Jefferson County).

The reference committee, in discussing each of these resolutions, voiced the opinion that withdrawing any approval of the program or the withdrawal of committees from the program would not aid in its improvement.

We, therefore, recommend that in lieu of the above-named resolutions, the following substitute resolution be adopted, which is, in effect, Resolution K with the deletion of one whereas. The substitute resolution is quoted below:

"WHEREAS, the Kentucky Medical Assistance Program has failed to realistically provide for the medically indigent of this Commonwealth as intended by Congress or understood by the public, and

"WHEREAS, the Kentucky Medical Association has since 1960 cooperated with all branches of state government including the Health Department and the Department of Economic Security in good faith providing leadership and untold hours, days and weeks of officers' and other physicians' time and professional talent in an effort to make the program work for the best interest of the people, and

"WHEREAS, the program has been underfinanced, mismanaged and falsely presented to the public, it is time for the Kentucky Medical Association to inform the State Legislature, the Congress of the United States and the people of Kentucky about some of the important facts which have caused this impossible situation, and

"WHEREAS, during the last fiscal year (June 1969-1970) 19,500 surgical operations were performed on hospitalized Medicaid patients. The Medical Assistance Program did not provide physicians with any compensation for the performance of surgical procedures on these nearly 20,000 patients. The only "in hospital" benefits paid physicians for Medicaid patients is a small consultation or attendance fee, and

"WHEREAS, by the calculation of less than an average fee for each of these surgical Medicaid patients, it is immediately evident the physicians of Kentucky are subsidizing the Medicaid program an estimated two million dollars ($2,000,000) per year for surgical patients and similar sums for 18,000 hospitalized seriously ill patients not requiring surgery, and

"WHEREAS, there are inequities in the program where physicians are expected to provide their "outpatient" professional services at far less than the usual, reasonable and customary fees charged by doctors in the community, and

"WHEREAS, the most recent KMAP booklet entitled, "What It's All About," published by the Kentucky Department of Health in August, 1970, is misleading in those sections which discuss the benefits under the program or the benefits to physicians as providers, and

"WHEREAS, compensation for "in-patient" hospital services available to physicians under the Medicaid program, with few exceptions, requires that the physician accept a fee less than that provided by the average standard health insurance policy; and further no other provider of health services has been expected to continue to provide services without just compensation, and

"WHEREAS, the program further leads the public to believe that doctors are paid adequately for all services, therefore be it

"RESOLVED, that this resolution, along with accompanying additional information, be provided to the Congressmen and Senators from Kentucky as well as the Governor and responsible officers in the Commonwealth, requesting that the facts regarding Medicaid be made known to the public so that they may understand why physicians find it economically difficult to continue seeing and caring for patients under the Medicaid Program, and be it further

"RESOLVED, a copy of this resolution together with additional information be provided to the news media in order that the public may be better informed regarding the fact that, in the future, physicians may prefer to see indigent patients in the manner of honored tradition rather than to accept the false premise and conduct of Medicaid."

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded.)

A lengthy and thorough discussion followed, during which both the supporters and opponents of this resolution spoke. At one point, the following amendment that an additional resolve be added to the substitute resolution proposed by the reference committee was moved and seconded: "And be it finally resolved that the House of Delegates of KMA hereby withdraws its approval of the Kentucky Medical Assistance Program and withdraws all of its committees to said program effective October 1, 1970, until such time that the Kentucky Medical Assistance Program shows evidence of good faith and reasonable plans of adequate implementation of such a program."

Additional discussion was held on this amendment. Finally the question was called, and the amendment was defeated. The original motion was then adopted as presented.

Resolution D

Campbell and Kenton County Medical Society

WHEREAS, the activity of Peer Review Groups is becoming increasingly necessary for the operation of third party pay plans and for providing maximal protection to the patients, to the providers of medical care, and to the third parties; and

WHEREAS, expanded use of such plans and increased activity of such Peer Review Groups can be anticipated further encroaching upon the productive time of the physician members of the Review Committee; and

WHEREAS, this activity represents an expenditure of voluntary physician time previously uncompensated; therefore be it

RESOLVED, that the KMA Board of Trustees be instructed to appoint an Ad Hoc Committee to investigate the advisability and the feasibiltiy of developing a mechanism for compensating physicians on such Peer Review Committees for the time and effort expended in the activities of such Committees; and be it further

RESOLVED, that all Peer Review Groups in the State of Kentucky including Utilization Review Committees at the hospital and county society will be urgently requested to compute the number of physician hours expended in these activities and through the KMA Headquarters, to report these figures to the Ad Hoc Committee from time to time; and be it further

RESOLVED, that each individual District Trustee be charged with the responsibility of insuring that these figures are kept up-to-date; and be it further

RESOLVED, that this Ad Hoc Committee be instructed to present a preliminary report to the Board of Trustees at the 1971 Interim Meeting and to present a final report with its recommendations to the House of Delegates at the 1971 Annual Meeting; and be it further

RESOLVED, that copy of this resolution be sent to each component medical society in the state and to each hospital in the state in order to compute the average number of hours so expended.

Recommendations, Reference Committee No. 5

Reference Committee No. 5 has reviewed Resolution D, introduced by the Campbell-Kenton County

Medical Society, concerning Peer Review. The committee recommends the approval of this resolution.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Resolution E

Campbell and Kenton County Medical Society

WHEREAS, the activity of Peer Review Groups is becoming increasingly necessary for the operation of third party pay plans and for providing maximal protection to the patients, to the providers of medical care, and to the third parties; and

WHEREAS, expanded use of such plans and increased activity of such Peer Review Groups can be anticipated further encroaching upon the productive time of the physician members of the Review Committee and

WHEREAS, this activity represents an expenditure of voluntary physician time previously uncompensated; therefore be it

RESOLVED, that any organization that requires the services of any review committee be responsible for compensating any physician for the amount of time he spends in his review committee activity.

Recommendations, Reference Committee No. 5

The reference committee has reviewed Resolution E, introduced by the Campbell-Kenton County Medical Society, concerning Compensation for Peer Review Activity.

The reference committee recommends postponement of action on this resolution until the study concerning physician hours spent in peer review has been compiled.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Resolution L

Jefferson County Medical Society

PREFACE

There are times when mechanisms constructed by the Federal Government are so constricting as to be a disservice both to persons needing to receive a service and to those persons wishing to provide that service.

One such situation proving to have this duality that is harmful exists in the Medicare mechanism. Specifically, this is apparent in the matter of "freezing" fees, thus locking a physician into a situation where he must eventually provide a service at a damaging loss, or no longer provide that unprofitable service at all.

The particular instance to be considered concerns the matter of Medicare payment for physician office calls.

On December 31, 1968, the fees for calls were "frozen" at the level of that date, and thenceforth Medicare would pay 80% of that fee, after the Medicare deductible of $50.00.

If, in line with rising costs at that time and with the awareness of the continuing rise of costs, a physician had, prior to the freeze, placed his fee for an office call at $7, that physician would find that his $7 fee, as of the Fall of 1970, would be considered the usual, reasonable and customary fee.

However, had that same physician had a $5 charge for an office visit at the time of the "freezing" of fees, then in the Fall of 1970, that physician would still be frozen at the $5 level for Medicare patients, and would find that that fee has long since been outrun by inflation. He would further find that the gap between his fee and reality would be widening month by month, with no "satisfactory" recourse or option in sight.

The word "satisfactory" is used because the physician does have an option to seeing a patient at a financial loss. He can refuse to see the Medicare patient at all. The physician, generally, considers this a highly unsatisfactory option, as it violates his idea of the practice of medicine.

However, the Medicare system was originally advanced, and since defended, by its proponents as being one that would benefit the general cause of health care, giving the elderly the means to afford care, helping the recipient maintain self-respect through the feeling that services received were paid for and that he was not a charity patient, and giving the provider of care, the physician, a realistic income for his services, one that would allow him to maintain his facilities and personnel necessary to provide the best health care possible to the greatest number of people.

WHEREAS, the "freezing" of physicians's fees for office visits has produced an aritifical subsidy by the physician of the Medicare system, and

WHEREAS, a system that "freezes" fees without review or satisfactory recourse is actually hampering the physician in his efforts to provide the most efficient facilities, retain experienced personnel, and attract competent new employees, and

WHEREAS, some physicians have been forced by economic necessity to exercise the option provided by the Medicare Law of refusing to see Medicare patients, or accept the Medicare "frozen" fee for office visits, and

WHEREAS, it is evident to many physicians that recipients of Medicare benefits frequently feel that Medicare pays the physician (after the $50 deductible), 80% of whatever fee he might care to charge, not realizing that the 80% is based on a "freeze" that in a great majority of the cases is unrelated to today , and that the disparity between the Government fee and the true cost is everyday making the recipient once more a "charity" case, and

WHEREAS, a number of physicians have chosen to practice in areas that bring to them a large number of elderly persons, beneficiaries of Medicare, and that each such patient may actually represent a loss or break-even situation, financially speaking, to the physician, not allowing him to afford the requirments of good practice under the enlarged modern work-load stimulated by Medicare. and

WHEREAS, the number of patients seen is no positive indicator of the profitability of a practice, particularly when those patients are "frozen" fee Medicare patients, and may actually be a negative indicator, therefore be it

RESOLVED, that the Kentucky Medical Association express its strong feelings that the "freeze" on office call fees is so severe in its limitations that it is depriving physicians of the ability to acquire the most modern service facilities, and to retain

and attract the most competent personnel, and as the matter now stands there is no end in sight to this situation, and be it further

RESOLVED, that the Kentucky Medical Association be asked to make the contents of the resolution and all the facts attendant thereto available to every physician in the State, and be it further

RESOLVED, that the Kentucky Medical Association convey this resolution to all local concerned Medicare officials, and further to all newspaper, radio and television personnel concerned with a presentation of the news in order that the facts of this situation might be known to the public, so that the public might properly judge the situation and what brings it about, and in the hope that some measures might be taken that would make it possible for physicians to see all patients for office visits, including those with Medicare, and be it further

RESOLVED, that this information be made available to all eligible Medicare recipients so that they may realize Medicare does not pay 80% of a realistic or usual and customery fee but 80% of a fee that has been long since, in many cases, made unrealistic by economic realities, and be it further

RESOLVED, that discussions be undertaken with Medicare officials and other interested and concerned parties to the end that this situation be set aright and a fee adjustment be permitted in the interest of the good practice of medicine, not merely for the period now under consideration but for the years ahead.

Recommendations, Reference Committee No. 5

The reference committee has reviewed Resolution L, submitted by the Jefferson County Medical Society, concerning Medicare. The reference committee recommends the adoption of Resolution L.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 5 as a whole.

(Motion was seconded and carried.)

Mr. Speaker, I would like to thank each member of this committee for his help in reviewing these reports and writing the reference committee report and to Mrs. Doris Crume who has typed our report.

REFERENCE COMMITTEE NO. 6

Glenn W. Bryant, M.D., Louisville Chairman
Thomson R. Bryant, Jr., M.D., Lexington
Billy G. Jackson, M.D., Princeton
Stephen B. Kelly, M.D., Somerset
Raymond D. Wells, M.D., Inez

REFERENCE COMMITTEE NO. 6

John F. Berry, Jr., M.D.,
Lexington, Chairman

Reference Committee No. 6 considered the following reports:

11. Report of the Judical Council

12. Report of the Rural Kentucky Medical Scholarship Fund, Board of Trustees

26. Report of the Committee to Study the Constitution and Bylaws

27. Report of the Interim Meeting Program Committee

28. Report of the McDowell House Board of Managers

29. Report of the Memorials Commission

44. Report of the Committee on Plans and Development

1. Report of the President, paragraphs 11 and 12 on pages 3-4 only

5. Report of the Chairman, Board of Trustees, Finance Committee Report only

30. Committee on Legislative Activities, last paragraphs on page 33 and paragraphs 1 and 2 on page 34 only

Resolution N—Election of Officers (Hardin County)

Report of the Judicial Council

The Judicial Council held four regular meetings and one special meeting during the Associational year in the course of which it considered thirty (30) different matters having ethical implications, of which five (5) were carried over from the previous year and twenty-five (25) were new. Fifteen of the new matters were in the nature of complaints and ten were inquiries as to the ethicality of certain practices.

Actions of general interest to the profession included the following rulings:

1. That unless the claiming physician has personal knowledge of the facts, the operating surgeon must certify to the fact that a nurse administered a certain anesthetic to his patient before a claim can be presented to Blue Shield on her behalf.

2. That there would be no breach of ethics in physicians' conveying instructive medical information to the lay public over TV, provided it was in the public interest and done with the sanction and under the direction of the county society. The Council warned that it would be improper for one group or clinic to act independently in this regard, without county society sanction or direction, and to the exclusion of other qualified members of the society.

3. That it is not *unethical* for physicians to consult with one another in the fixing of relative values for units of service, or in fixing the dollar value of each unit, so long as the resulting fee is reasonable and does not amount to exploitation of the patient. (The Council expressed no opinion as to the *legality* of such consultation, under the anti-trust laws.)

4. That it is not unethical for the medical staff of a hospital to recommend denial of surgical and obstetrical privileges to a physician who does not have a narcotics license.

5. That it is not unethical for pathologists who own laboratories to circularize the profession with material showing the services available from their laboratories and the fee for each service, but that

the physician should not follow this mailing with a personal visit to "explain" or amplify the written solicitation even though the omission of this follow-up may place the physician's laboratory at a competitive disadvantage.

6. That although a county society may not declare unethical a practice declared by the AMA to be ethical, it may "deplore" such a practice and thereby exert moral persuasion against it.

7. That hospital-based physicians must not allow the hospital to bill patients for their professional services without clearly showing on the bill the name of the physician who performed the service and that the hospital is merely a collecting agent for the named physician.

8. That a physician should not use a professional (business) card which lists the "treatments" he offers to give, but should limit the card to his name, the title "Doctor of Medicine" or "M.D." and if desired, the abbreviations signifying any board certified specialty.

9. That it is not unethical for a physician to accept free office or living quarters as an inducement to locate in a certain area.

10. That it is unethical for physicians or members of their immediate families to own stock in drug companies which are small enough to have their profits materially influenced by the prescription-writing of their physician-stockholders. The Council said:

> "The physician-patient relationship is such that the patient must repose complete confidence in the skill, judgment and integrity of his physician and we believe that this relationship would be damaged if the patient were to have *any* reason to doubt that *every* decision was based solely upon his physician's best *medical* judgment."

11. That it is ethical for a physician to ask his patients to assign their insurance claims to him but that he must not insist upon this as a condition to his filling out the claim forms.

12. That the Council approves Res. 71, adopted by the AMA House of Delegates, which provides that a physician who has laboratory work done outside his office must show on his bill to the patient the name of the laboratory and the charge made by it and must separately state any handling charge which he may make.

13. That a surgeon may ethically use a trained lay "technician" to assist him in his operations, but that this "technician" may not serve as a surgical "assistant" where such assistance is required for major surgery.

14. That the medical staff of a hospital, through restriction of privilege, is best equipped to deal with incompetence due to age and other infirmities, at the local level.

Because of its increasingly heavy work-load, the Council has voted to meet bi-monthly instead of quarterly for the indefinite future. It earnestly solicits the aid and assistance of the membership in bringing to light evidence of unprofessional conduct of any and every kind.

N. Lewis Bosworth, M.D., Chairman

Recommendations, Reference Committee No. 6

The Report of the Judicial Council was considered. The committee approves the Report of the Judical Council and recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Rural Kentucky Medical Scholarship Fund

A million dollar milestone was reached at the 24th annual meeting of the Rural Kentucky Medical Scholarship Fund held on May 14, 1970. The Scholarship Board approved 33 new and renewal loans amounting to $65,500. The Fund, since its beginning, using the revolving funds available, has now loaned over one million dollars.

The Fund, established in 1946, for the purpose of providing a better distribution of physicians in rural Kentucky, now has 161 physicians in practice in 86 counties with 13 serving in "critical" counties.

There are now outstanding 347 notes to 141 recipients for a total in excess of $459,000, most of whom are either in medical school, interning or in the armed services.

All loans and contracts are processed at the KMA Headquarters Office. Progress reports are secured on students in medical school, and contact is maintained with interns, recipients in the armed services, those in specialty training and past recipients in practice. The Louisville Trust Company serves as the Fiscal Agent for the Fund. A quarterly financial report is submitted to the Board of Trustees of the Fund.

Loans are available to residents of Kentucky who have been admitted to an accredited medical school, and who will agree to practice in rural Kentucky for one year for each loan received. Currently the Fund will lend $2,500 to applicants who will agree to practice in counties listed as "critically in need of

physicians", or in the Kentucky Public Health Service in an approved area. One year's loan is waived for each year of practice.

Regular loans of up to $1,500 per year at an interest rate of 2% to maturity permit practice in over 100 rural counties in the state. Should a student later decide to practice in a "critical" county, one year's loan will be forgiven for each year of practice. One half a year's loan for each year of practice in a "semi-critical" area will be forgiven.

The 10 critical counties selected for 1970-71, on the basis of information supplied in April by the Kentucky Medical Association and the State Board of Health, are: Jackson, Carter, Butler, Knott, Crittenden, Lee, Powell, Lewis, Meade and McCreary. Semi-critical areas selected are: Rockcastle, Lincoln, Bracken-Robertson, Garrard, Magoffin-Breathitt, Clay-Owsley, Metcalfe-Clinton-Cumberland, Estill, Edmonson and Owen-Gallatin.

Sixteen of the 1970-71 loan recipients have agreed to practice in counties listed as "critically in need of physicians".

The Fund also has provided for Establish Practice Loans as an assistance to physicians who will agree to establish practice in a "critical" or "semi-critical" county. The Board will loan $2,000, repayable at the rate of $1,000 per year. The Fund will forgive $1,000 of this amount for each year of practice in a "critical" county, and one-half of this amount for each year of practice in a "semi-critical" area.

The Trustees have elected Douglas M. Haynes, M.D., Dean of the University of Louisville School of Medicine, and John Meisenheimer, Ph.D., of Eastern State University, Richmond, Kentucky as new Board members.

The Board of Trustees is especially appreciative of the continued interest and support of Governor Louie B. Nunn, Health Commissioner Russell E. Teague, M.D. and the Kentucky General Assembly.

C. C. Howard, M.D., Chairman

Recommendations, Reference Committee No. 6

The Report of the Rural Kentucky Medical Scholarship Fund, Board of Trustees, was reviewed. The committee recommends that this report be accepted and commends the Fund for a job well done.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Committee to Study the Constitution and Bylaws

Your Committee to Study the Constitution and Bylaws met this year on June 11 for its annual session to implement bylaw changes that had been proposed to the committee and to generally attempt to update the bylaws.

The committee last year encouraged our committee members to make a comprehensive study of the bylaws and modernize them where appropriate. The committee did give considerable preparation to their meeting and we are proposing a number of changes which are primarily updating the bylaws. You might note that a few of our changes result from the fact that the bylaws have not been modernized in some instances since KMA has had more than one executive staff member.

There is one area of the bylaws in which we have not completed our study and this is in reference to Section 2, Chapter I relating to membership. We feel that a day long study needs to be given to this classification alone if we are to align the bylaws of KMA as closely as possible with those of AMA. We recommend that a subcommittee of the Constitution and Bylaws Committee meet early in the next Associational year for the particular purpose of modernizing this particular section of the bylaws. (We would hope that after next year's bylaws have been finalized with the new membership changes proposed, that they would become a model bylaws for all the county medical societies.)

We hope that it is some help to you in interpreting our report for us to use the following format. First, we will present our recommendations and reasons for submitting any proposed changes. Secondly, we will quote the wording of the present section of the Constitution and Bylaws and thirdly, present the proposed amendment to the Constitution and Bylaws.

Other than the modernizing changes being made by the committee members, there are specific changes being made that have been referred to us by the Board of Trustees, resulting from a study by the Ad Hoc Committee on Finance. The Board of Trustees has recommended that KMA dues be increased from $80 to $130 per year and that there be no difference between the amount of dues for all active members of the Association with the exception that new members would pay only $80 dues per year during their first three years of active membership.

This recommendation would also require a change in Article IX of the Constitution since we would not have an "equal per capita assessment by class of membership."

Amendments To The Constitution

RECOMMENDATION

To implement the above mentioned Board of Trustees recommendation, we propose that the phrase relating to "equal per capita" be deleted. Since changes to the Constitution must lay over for one year before the change can be finalized, we would suggest that the Board of Trustees use the power provided them in Chapter I, Section 1 of the By-laws during this first year to accept a lesser amount of dues from new members. Without regard to the current recommendation being made by the Board, your committee still feels that this proposed change should be approved to allow more flexibility in funding the Association's operations.

ARTICLE IX, Funds and Expenses

Present Article: The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select including but not limited to an equal per capita assessment by class membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Proposed Article: The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session for publications and for such other purposes as will promote the welfare of the Association and the profession.

Amendments To The Bylaws

RECOMMENDATION

The Board of Trustees has recommended that new members be given three years instead of two years to complete their orientation course. The Board of Trustees will exercise their own judgement in deciding how many times per year the course should be offered.

CHAPTER I, Membership

Present Section 5: Every new member shall be required to attend and successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within two years after the member is first admitted to active membership shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter for a period of one year, be ineligible for membership in any component society, and shall not after one year be admitted to membership unless and until he has successfully completed the required orientation course.

Proposed Section 5: Every new member shall be required to attend and successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within three years after the member is first admitted to active membership shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component society, and shall not after one year be admitted to membership unless and until he has successfully completed the required orientation course.

RECOMMENDATION

For many years the proceedings of the House of Delegates have been published annually in the December issue of the KMA Journal. There are no present plans to make any change in this. However, it is possible that there may be a good reason some year to publish the digest of proceedings separate from the Journal. The main thing is that they be published annually and submitted to the membership. This is a modernization change.

CHAPTER III, The House of Delegates

Present Section 19: A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

Proposed Section 19: A digest of proceedings of the House of Delegates shall be published *annually*.

RECOMMENDATION

There is much time consuming responsibility conferred upon our president and it is the feeling of our committee that the president should have the choice of visiting all Trustee District Meetings or have an opportunity to send speakers to discuss subjects that he feels to be of priority to the society.

CHAPTER V, Duties of Officers

Present Section 1: Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Proposed Section 1: Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for.

He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit *or cause to be visited on his behalf,* the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President.

RECOMMENDATION

At the request of the Budget Committee, the Board of Trustees has made changes in the budget classifications and allocations which would require a modernization of the bylaws by deleting the last three words of Section 4, Chapter V.

CHAPTER V, Duties of Officers

Present Section 4: The President-Elect and the Vice-President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Proposed Section 4: The President-Elect and the Vice-President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses.

RECOMMENDATION

Because of the complex duties of the Executive Director and since there is now more then one full-time member of the Executive Staff, your commitee feels that there are changes needed in Section 7, Chapter V of the bylaws if they are to be updated in accordance with our instructions. The phrase proposed for deletion is covered in Section 9, Chapter VI.

CHAPTER V, Duties of Officers

Present Section 7: The Secretary shall advise the Executive Director in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Director, shall assume the duties of that office until the vacancy is filled.

Proposed Section 7: The Secretary shall advise the Executive Director in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws.

RECOMMENDATION

Changes have been suggested in the duties of the Trustees which are felt to be keeping with our modernization commitment.

CHAPTER VI, Board of Trustees

Present Section 3: Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Proposed Section 3: Each Trustee shall be organizer, peacemaker and censor for his district. He shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

RECOMMENDATION

We must react promptly in the world of today's communications media and we have made a suggested change in Section 4, Chapter VI of the bylaws which we feel will be of assistance in accomplishing this goal.

CHAPTER VI, Board of Trustees

Present Section 4: The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Proposed Section 4: The Board shall have the *authority* to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press.

RECOMMENDATION

Continuing to try to modernize the bylaws, we have suggested a couple of changes in two paragraphs of Section 9, Chapter VI. We will print in this report only those two paragraphs which we are proposing to change, along with our proposed changes of these two paragraphs. The remainder of Section 9 would remain the same.

We feel these two changes provide the Executive Director with more flexibility should he find a

better method of maintaining records for our physicians (such as computers) or should he desire to appoint another staff member as Managing Editor of the KMA Journal.

CHAPTER VI, Board of Trustees

Present Section 9 (Paragraphs 5 & 6): He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

Proposed Section 9 (Paragraphs 5 & 6): He shall keep a *record* of all *physicians* in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor, *or otherwise supervise the publication of the Journal of the Kentucky Medical Association and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.*

RECOMMENDATION

As previously mentioned in this report, the proposed changes in dues are presented at the request of the Board of Trustees.

CHAPTER IX, Assessments and Expenditures

Present Section 1: The annual dues for membership in this Association shall be as follows: (1) Active Members $80, except Active Members who devote all of their time to teaching or research and have no private practice, $55; (2) Emeritus Members, no dues; (3) Associate Members, $10; (4) Inactive Members, $10; (5) Student Members, $1; (6) Service Members, no dues; (7) Special members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Proposed Section 1: The annual dues for membership in this Association shall be as follows: (1) Active Members, $80 *for each of the first three years of active membership in this Association and $130 thereafter;* (2) Emeritus Members, no dues; (3) Associate Members, $10; (4) Inactive Members, $10; (5) Student Members, $1; (6) Service Members, no dues; (7) Special members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessments together with its *properly classified* roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

RECOMMENDATION

Section 3, Chapter XII was obviously written before all county medical societies had been chartered. Today all county societies are chartered so the first sentence of Section 3 is really no longer necessary. We note that it also conflicts with a sentence in Section 5 of the Bylaws which authorizes the Board of Trustees to issue charters to multi-county societies. This, of course, is issuing a charter to a group of county medical societies who already have their own individual charters. Your committee therefore recommends the deletion of the first section of Section 3.

CHAPTER XII, County Societies

Present Section 3: Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Proposed Section 3: The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

RECOMMENDATION

Our proposed deletion of two words (the younger) in Section 11, Chapter XII is self-explanatory your committee believes. Obviously, we think this should apply to all members.

CHAPTER XII, County Societies

Present Section 11: Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Proposed Section 11: Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. Members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

RECOMMENDATION

We believe that Section 14, Chapter XII of the Bylaws was approved at a time when we had a fewer number of county medical societies, all of which had less to do and report than our societies do today. We still urge the component societies to report matters of interest to KMA and to the Journal but we believe that the deletion of Section 14 is indicated.

CHAPTER XII, County Societies

Present Section 14: The Secretary of each component society shall report to the Journal of the

Kentucky Medical Association full minutes of each meeting and forward to all scientific papers and discussions which the society shall consider worthy of publication.

Proposed Section 14: (Delete entire Section.)

Robert L. McClendon, M.D., Chairman

BOARD ACTION: Approved, with the recommendation that the words, "and distributed to the membership", be added following the word, "annually," in the proposed Section 19 of Chapter I.

Recommendations, Reference Committee No. 6

The committee reviewed the Report of the Committee to Study the Constitution and Bylaws and recommends the adoption of the report with the following exceptions:

With respect to Chapter III, Proposed Section 19 (page 25 in the Reports booklet), the committee recommends that this section read as follows:

"A digest of proceedings of the House of Delegates shall be published and distributed to the membership annually."

With respect to Chapter IX, Proposed Section 1 (page 27 in the Reports booklet), the committee recommends that this section read as follows:

"The annual dues for membership in this Association shall be as follows: (1) Active Members $130, except that the dues for new members entering practice for the first time shall be $80 per year for the first three full years of practice." (The balance of this section remains unchanged.)

With respect to Chapter XII, Proposed Section 3 (page 27 in the Reports booklet), the committee recommends that this section be adopted but that it be attached to present sub-section 1 of that chapter and that succeeding sections be renumbered accordingly.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Report of the Interim Meeting Program Committee

The Interim Meeting Program Committee met Wednesday evening November 12, 1969, at the Village Inn, Kentucky Dam Village State Park, Gilbertsville, to plan the 1970 session to be held in that location. Originally, the Interim Meeting was scheduled for the new Barkley Lodge but was moved to Kentucky Dam Village when it was determined that Barkley Lodge would not be completed in time and that the Village Inn would be very satisfactory for our meeting.

After reviewing the format of recent Interim Meetings, the committee agreed to design the 1970 program similar to those held in the past. Plans were made for promotion of attendance and the Woman's Auxiliary agreed to lend their usual appropriate support.

Details were finalized for the three sessions scheduled which were the opening dinner session on Wednesday evening April 8 (to feature Russell B. Roth, M.D., Speaker of the AMA House of Delegates), the following morning's general session, and the closing luncheon meeting. Coordination of the Orientation Program, Board of Trustees and other related meetings held in conjunction with the Interim Session was authorized.

"Kentucky Medicine in the 1970's" was the theme selected and it was agreed that two panel presentations would be on the Thursday morning program relating to the subjects of "The Physician's Assistant" and "Peer Review." Speakers were then chosen for the individual and panel presentations and the committee expressed their desire to invite Mr. J. Ed McConnell, President of Kentucky Blue Cross and Blue Shield to be the final speaker at the luncheon session.

The committee members feel that the 286 physicians, Auxiliary members and guests that registered for the meeting represented an excellent attendance for a session being held in a non-central section of the state. Your committee wishes to express its appreciation to the Pennyrile Medical Society and the Woman's Auxiliary for their cooperative efforts in helping make this program a success.

Walter L. Cawood, M.D., Chairman

Recommendations, Reference Committee No. 6

The committee reviewed the Report of the Interim Meeting Program Committee and recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the McDowell House Board of Managers

Your Committee reports that the McDowell House, Apothecary Shop and the Garden are in excellent condition.

Annual repairs to the architecture have been carried out. Gradual and continuous repairing are necessary. Certain rugs, curtains and steps to the Apothecary Shop have been renewed or replaced.

More than 3,000 visitors from over the country and abroad have visited the House during the year.

An inventory of the McDowell House was completed in December, 1969. A project to catalogue and have evaluated each antique in the House is underway, in order to have proper insurance on the valuable furniture and paintings. Insurance policies on the House and its contents have been reviewed.

A documentary on the McDowell House is being prepared by Mr. Bob Kay of WAVE-TV; a copy of the film has been requested for the House.

In February, 1970, a House rug bee resulted in many hours of volunteer work in repairing and binding the rugs in the House.

Engraved brass plates have been placed on the eight family portraits by the Danville and Boyle County Historical Society.

The garden this year has been improved immeasurably under the expert care of Mrs. Corinna Balden.

A budget prepared by Doctors Blaine Lewis, Eugene Conner and the Administration was adopted and referred to the Budget Committee.

During the year the County Medical Auxiliaries have been actively involved in improvements in the McDowell House. Several have made contributions for replacement of the furniture. The Fayette County Auxiliary is completely redoing their bedroom with Mrs. Alfred Marks as decorator, and with approval of Mr. James Cogar of the Board of Managers. Correlation of the auxiliary work and the responsibilities of the Board of Managers has been greatly augmented by Mrs. West T. Hill, Secretary of the House.

On June 6, 1970, the Innominate Society for the Study of Medical History, with Ellis Fuller, M.D., as President, and Melvin Bernhard, M.D., as host and Speaker, held a meeting at the House. The availability of the House for such a purpose should be known to all members of the profession. Every member of the Kentucky Medical Association should make an effort to visit *his* House frequently.

Laman A. Gray, M.D., Chairman

Recommendations, Reference Committee No. 6

The committee reviewed the Report of the McDowell House Board of Managers and recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the KMA Memorials Commission

The Memorials Commission held one meeting this past year, on June 18, 1970, at the KMA Headquarters.

The Commission takes pleasure in acknowledging receipt of several items from members of our Association. N. L. Bosworth, M.D., Lexington, sent us a copy of *Buchan's Domestic Medicine* and David M. Cox, M.D. donated a mercury baumanometer. In addition, committee member J. Duffy Hancock, M.D., Louisville, gave a set of cervical dilators which were used around 1890. These items are on display in the bookcase in the President's Office at Headquarters.

The Commission was successful this year in having the name of the street on which the Headquarters Office is located changed from Janet Avenue to Ephraim McDowell Drive. The Commission has also been active in trying to locate a picture of William L. Sutton, M.D., KMA's first president, in order to have a portrait made from it.

The Commission continues its search of copies of *Transactions of the KMA* and is now in the process of determining the feasibility and cost of obtaining microfilm or xerox copies of extant *Transactions* from various libraries. It is hoped that we may assemble one complete file of these important records of our Association.

The Commission will have an exhibit at the KMA meeting memorializing John A. Ouchterlony, M.D., who became President of KMA in 1890. In addition, we plan to display a number of publications authored by Kentucky physicians prior to 1900.

Eugene H. Conner, M.D., Chairman

Recommendations, Reference Committee No. 6

The committee reviewed the Report of the Memorials Commission and recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Plans and Development Committee

The Plans and Development Committee held three meetings during the past year. Each meeting was for the most of the day, and all meetings followed similar format.

Only one topic was considered at each meeting, the committee making an attempt to study the topic in depth through the use of outside consultants in each field. Committee discussion was held first with the consultants and then by the committee members alone. Finally, the committee formulated recommendation to the Board of Trustees for its consideration and action.

The first meeting was held February 5, 1970, and the topic was "Professional Liability Insurance." Consultants were Mr. Riley Lassiter of the Medical Protective Company and Mr. Jo Van Zandt of the Aetna Casualty Company. After comprehensive reports on the present and future status of this type of insurance by the consultants and after discussion of various aspects of the many problems and possible solutions a full report was presented to the Board of Trustees.

The committee noted that it was not only possible but probable that two of the currently popular solutions being tried will in the long run work to the detriment of the physician policyholder. Mainly the "malpractice screening panels" will work for the plaintiff regardless of the justification for his complaint, and "group plans" of state societies have resulted in still higher premiums than that charged by the traditional carriers.

After considering pros and cons of possible actions by the Kentucky Medical Association, it is the Plans and Development Committee's belief, and it was our recommendation to the Board of Trustees, that the best course to follow includes:

(1) Education of our present and future members and our office assistants by

(a) an hour-long professional liability presentation at the KMA Interim Meeting.

(b) Making professional liability a part of "Senior Day" and "Orientation" programs.

(c) Urging medical schools to devote adequate time in their curriculum to this subject.

(d) Asking KMA members to encourage their office personnel to belong to the State Association of Medical Assistants which regularly holds continuing educational programs on this subject.

(e) Publishing articles in the KMA Journal, and

(f) Conducting District Meetings with medical liability insurance as the program or part of the program.

(2) That the Kentucky Medical Association reaffirm its opposition to "screening panels" even

though a then-current AMA Report R supported them. (This was done through a resolution to the AMA.)

(3) That the Kentucky Medical Association establish a Committee on Medical Economics to provide an on-going study and to provide information to our members not only about this subject, but on other socio-economic matters of importance to doctors such as corporations, partnerships, business management, etc. We were pleased that all of our recommendations were adopted by the Board of Trustees at its April meeting.

The second meeting of the Plans and Development Committee was on a topic of providing a common building and umbrella of services to specialist organizations in Kentucky. The organizations which were represented at this meeting were: Kentucky Association of Public Health Physicians; Kentucky Obstetrical and Gynecological Society; Kentucky Chapter, American College of Radiology; Jefferson County Medical Society; Kentucky Chapter, American Academy of General Practice; Kentucky Eye, Ear, Nose and Throat Society; Kentucky Chapter, American College of Physicians; KMA Committee on Legislative Activities; Fayette County Medical Society; Kentucky Society of Pathologists; Kentucky Chapter, American College of Surgeons.

The coordination of administrative and secretarial help was discussed, and it was generally agreed that it would be beneficial to all concerned. Material was presented and reports were furnished of similar efforts in other states. These services have been furnished in most instances at a considerable bargain to the organizations involved and all concerned agreed that the benefits were enormous. The committee felt that one of the most important gains for such a set up in Kentucky would be the close reknitting together of all specialty organizations and thus all physicians in presenting a united front for the common good of our patients and ourselves. Another important gain would be that it would be possible to have coordination and rationality in postgraduate educational programs that do not now exist. The Committee made the following recommendations to the Board of Trustees: (1) The formation of an Inter-Specialty Council similar to the AMA Inter-Specialty Council and that this body include a representative of each SAMA chapter in Kentucky as well as the specialty groups. This council would provide the framework and guidelines to institute the above-mentioned proposal as well as other items of common interest. (2) The coordination of administrative services as mentioned above also be offered to interested county medical societies. (The Board of Trustees will act on these proposals at its August meeting.)

The third meeting of the Plans and Development Committee was held on June 10 to discuss the topic of public relations for KMA. Presentations were made by two firms, Bennett and Wyatt Associates, Inc. and the Ted Tighe Advertising Agency. Again the committee discussed pros and cons and cost. The committee members felt that the benefits of such help should be great to the Association. It was made clear that public relations does not mean "advertising", but it means having the "know-how" and using the proper methods of getting our (medicine) story told to the public.

It was felt that such a program should properly include (1) The public relations impact of what the Kentucky Medical Association is now doing. (2) Media relations and internal communications. (3) Public service initiative or leadership. After exhaustive consideration, the committee felt that this recommendation would be appropriate.

(1) A Kentucky Medical Association Public Relations Committee be appointed and that a public relations consultant be employed.

(2) That an allocation of $3,000 be authorized in the budget for this purpose to have a six-month trial period in the coming year with an additional $3,000 put aside in reserve fund for the second six months should it be desirable to continue this arrangement.

(3) When the committee presents its above proposal to the Board of Trustees on August 6 it will also recommend which specific PR firm it feels would be most beneficial to KMA.

This concludes the report summarizing the activities and recommendations of the Plans and Development Committee for the past year. It has been a distinct pleasure to work with the committee members and guests. We have enjoyed the cooperation of not only the KMA staff but of outside consultants that we have called in.

Thornton E. Bryan, Jr., M.D., Chairman

Recommendations, Reference Committee No. 6

The committee reviewed the Report of the Committee on Plans and Development and recommends the adoption of this report with the provision that the paragraph relating to the allocation of funds to be used by the Public Relations Committee be contingent upon the dues increase as previously approved by the Board.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Report of the President

(paragraphs 11-12 only, pages 3-4, in Reports Booklet)

Gentlemen, nearing the end of my term of office as your President, I would be most remiss in my duty unless I recommended your serious, thoughtful consideration of the proposed dues increase which has been presented to you by the Ad Hoc Committee on Finance. This top-drawer committee headed by Henry B. Asman, M.D., has assembled the information for you.

Our continued involvement in Governmental Relations, Peer Review, Health Manpower, Continued Medical Education, Rural Scholarship Program, Public Affairs, and other fields of medical administration has stretched our budget to the breaking point. Further, the last major dues increase was in 1964. You know what inflation for six years has done to our dollars for general operation and administrative expenses. The cost of living is up 25%. Just to stay even, which is not good enough, demands more money. If KMA is to progress, to grow, to meet the continuing demands of the public, the Government

and our profession, finances must be increased to operate with enough reserve. After serious and profound consideration of this proposal the needed action is obvious if the Association is to properly represent you.

Report of the Ad Hoc Committee on Finance

Your Finance Committee conducted surveys and made an indepth study of KMA's financial structure, current and future needs. The members of this committee are to be commended for an excellent job. The committee has recommended a dues increase from $80 to $130 for all active members. Your Board of Trustees, at its April meeting, wholeheartedly endorsed this recommendation and urges your favorable consideration of it to assure the continuing activities and progressive action needed by the Association in behalf of our profession. In this report I will not discuss the details of the Finance Committee's study but would direct your attention to the special report, in your House of Delegates envelope, which appeared originally in the June issue of *The KMA Journal*.

Report of the Committee on Legislative Activities

(last paragraph, page 33, and paragraphs 1 and 2, page 34, in Reports Booklet)

While many things have created a need for more funds in every aspect of organized medicine, I feel these same reasons are more than double in the area of legislative affairs. It is obvious that the consumer is playing an increasing role in health care matters, and the "popularity" of health matters requires us to exert that much stronger leadership.

I strongly feel that the budget for the Committee on Legislative Activities must be substantially increased. More administrative expense will be incurred, and it may well be necessary by the time of the next General Assembly to seek part-time personnel for legislative affairs, which would require more funds than currently available, especially considering newly recommended proposals and activities.

Since this committee will be served by a new chairman next year, perhaps this is the best time to state that serious consideration should be given to providing the chairman with expenses. Realizing this organization is served by many committee chairmen, it must be understood that near and during the General Assembly the activities and expenses of this particular chairmanship are considerable.

Recommendations, Reference Committee No. 6

The committee considered the following reports together: Report of the President, paragraphs 11 and 12 on pages 3-4; the Report of the Chairman, Board of Trustees, Finance Committee Report; and the Report of the Committee on Legislative Activities, last paragraph on page 33 and paragraphs 1 and 2 on page 34. The committee recommends their adoption contingent upon acceptance by the House of Delegates of the proposed dues increase.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Resolution N

Hardin County Medical Society

WHEREAS, the profession of medicine finds itself in a position of having to defend and protect the free and private practice of medicine for the good of both the profession and the general public, and

WHEREAS, we find it necessary to deal with third parties in the practice of medicine, and

WHEREAS, we find it more and more important to convey our ideas and opinions to both lawmakers and the general public, and

WHEREAS, changing times have made it necessary for the President of our organization to be responsible for the public relations of our organization, and

WHEREAS, consideration of individuals for KMA offices should be based on the ability of the individual and his or her desire to serve the organization and profession, and not based on geographical considerations, therefore be it

RESOLVED, that henceforth all officers of KMA, with the exception of Trustees, shall be elected from the state at large, and not from geographical districts, and be it further

RESOLVED, that at least two nominees shall be submitted for each office to be filled, excluding Trustees, and be it further

RESOLVED, that all members of KMA may feel free to actively seek any office of KMA as announced candidates and may feel free to present planned programs which the candidate would pledge to follow if elected, and be it further

RESOLVED, that the provision of this resolution shall become effective immediately upon passage by the KMA House of Delegates and that KMA Bylaws be changed accordingly.

Recommendations, Reference Committee No. 6

The committee considered Resolution N, Election of Officers, introduced by Hardin County, and recommends adoption fo this resolution.

To implement this recommendation, the following amendments to the Bylaws are required:

(a) Amend Chapter IV, Section 1 by deleting the sentence: "The vice-president shall be elected from the same general area in which the president resides."

(b) Amend Chapter IV by deleting Section 5 in its entirety.

(c) Amend Chapter IV, Section 2, the fifth literary sentence to read as follows: "Before noon of the following day, the committee shall post *on* a bulletin board near the entrance to the hall in which the Annual Meeting is being held, *at least two* nominations for each office, excluding Trustees, to be filled, and shall formally present said nominations to the House at the time of the election." Insert immediately following the aforementioned sentence the following: "All officers with the exception of Trustees shall be elected from the state at large and not from geographical districts."

The committee recommends the adoption of the aforegoing amendments.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded.)

There was considerable discussion about this resolution as well as the bylaw changes proposed by the reference committee to implement it. A motion was made and seconded to amend Chapter IV, Section 5, of the bylaws by substituting the following for that entire section: "A member may seek office and the Judical Council shall be responsible for establishment of guidelines delineating permissable limits of campaigning for the officers of KMA."

In that there was some confusion about the issue to be voted upon, a motion was made and seconded for a division of the question. This action brought forth additional discussion. A vote was taken on the matter of the division of the question, and it was defeated.

The vote on the amendment to the original motion was called and by a 64 to 31 count was adopted.

The original motion as amended was then voted upon and defeated by a 23 to 69 margin.

Mr. Speaker, I move the adoption of the report of Reference Committee No. 6 as a whole as amended.

(Motion was seconded and carried.)

Mr. Speaker, I wish to thank Mrs. Sandra Murphy for her typing of this report, the members of the committee for their attendance and help in the preparation of this report; and especially, I wish to thank our legal counsel, Mr. E. Gaines Davis, for his able assistance at this time.

REFERENCE COMMITTEE NO. 6
John F. Berry, Jr., M.D., Lexington, Chairman
George P. Archer, M.D., Prestonburg
James B. Cox, M.D., Hopkinsville
Edward N. Maxwell, M.D., Louisville
W. Vinson Pierce, M.D., Covington

Unfinished Business

Doctor Greathouse recognized William W. Hall, M.D., Chairman of the Board of Trustees, for the final report of the Board which read as follows:

The KMA Bylaws provide that the Judical Council be composed of five members, four of these members to be elected by the House of Delegates with terms staggered so that one member will be elected each year. The KMA Secretary, who is elected by the House, automatically serves as a member of the Council.

According to the Bylaws, Chapter VII, Section 1, "to be eligible for membership on the Judical Council, a nominee shall posses at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA, or (2) Have served five years as a member of the House of Delegates."

The bylaws provide that the Board of Trustees shall nominate at least one candidate for each vacancy and that additional nominations may be made from the floor.

The term of John Dickinson, M.D., Glasgow, expires with this meeting. The Board of Trustees has unanimously voted to nominate Doctor Dickinson to succeed himself for a four-year term.

Doctor Hall moved the adoption of this report.

(Motion was seconded and carried.)

Election of Officers

Speaker Greathouse called for the Report of the Nominating Committee from its Chairman, W. E. Becknell, M.D., Manchester. Dr. Becknell read the following list of nominations for the positons noted:

President-Elect (Central)	John S. Harter, M.D., Louisville
Vice-President (Western)	Richard F. Grise, M.D., Bowling Green
AMA Delegate	J. Thomas Giannini, M.D., Louisville
AMA Alternate Delegate	Charles G. Bryant, M.D., Louisville

After the presentation of each nomination, the Speaker called for nominations from the floor. As no additional nominations were received, it was moved and seconded that the nominees be elected.

(Motion was carried.)

Doctor Harter, the President-Elect, was escorted to the podium and received a standing ovation.

The following nominations for the office of trustee and alternate trustee were submitted by Doctor Becknell on behalf of the various district nominating committees:

Second District	Charles Kissinger, M.D., Henderson
Alternate	Kenneth M. Eblen, M.D., Henderson
Seventh District	Thomas P. Leonard, Sr., M.D., Frankfort
Alternate	John P. Stewart, M.D., Frankfort
Ninth District	James C. Cantrill, M.D., Georgetown
Alternate	James L. Ferrell, M.D., Paris
Tenth District	David A. Hull, M.D., Lexington
Alternate	Irving F. Kanner, M.D., Lexington
Thirteenth District	J. Wesley Johnson, M.D., Ashland
Alternate	Arthur B. Richards, M.D., Louisa

The same procedure employed in the election of the general officers was followed in the election of the trustees and alternates. There being no additional nominations from the floor, the above-named nominees were elected.

Nominations for Kentucky Physicians Mutual, Inc., Board of Directors

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc., was submitted and received for information only.

George P. Archer, M.D., Prestonsburg
Branham B. Baughman, M.D., Frankfort
W. K. Massie, Jr., M.D., Lexington
George W. Pedigo, Jr. M.D., Louisville
W. Vinson Pierce, M.D., Covington
R. W. Robertson, M.D., Paducah
Charles B. Stacy, M.D., Pineville
William P. McElwain, M.D., Frankfort
Lee C. Hess, M.D., Florence
David A. Hull, M.D., Lexington
Roy H. Moore, Jr., M.D., Louisville
Walter L. Cawood, M.D., Ashland
Nicholas Kavanaugh, Jr., M.D., Lexington

Election of 1971 Nominating Committee

The following physicians were elected by the House of Delegates to serve as the Nominating Committee for the 1971 Annual Meeting:

John Baird, M.D., Danville
John H. Doyle, M.D., Louisville
Kenneth M. Eblen, M.D., Henderson
Fred C. Rainey, M.D., Elizabethtown
Carl H. Scott, M.D., Lexington

Secretary Scheen asked for the floor and briefly spoke on the matter of the dues increase approved by the House of Delegates. He especially noted the hard work done on this matter by the Past-President, Henry B. Asman, M.D., Louisville, who willingly traveled across the state to explain the reasons for the proposed increase to various county societies.

John C. Quertermous, M.D., Murray, was installed as President, the oath of office being administered by the Chairman of the Board of Trustees, Doctor Hall. President Quertermous then presented the Past-President's Plaque to the retiring President, Walter L. Cawood, M.D., expressing appreciation for his service to the Association on behalf of the membership.

Dr. Cawood issued an invitation to members and guests to attend a reception in his suite immediately following the adjournment of the House.

As the new President-Elect, John S. Harter, M.D., briefly commented and thanked the members for their confidence in electing him to this high position and pledged his full support to the Association.

Dr. Scheen announced that the Board of Trustees would hold its reorganizational meeting on Thursday, 12:00 noon, Parlor A in the Kentucky Hotel and urged the newly elected Board members to attend.

Speaker Greathouse adjourned the second session of the 1970 House of Delegates at 10:50 p.m., thanking the delegates for their diligent work.

27th Annual

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1970 CONSTITUTION AND BYLAWS

OF THE

KENTUCKY MEDICAL ASSOCIATION

Revised September 23, 1970

CONSTITUTION

Article I.	Name of the Association
Article II.	Purpose of the Association
Article III.	Component Societies
Article IV.	Composition and Meetings of the Association
Article V.	Officers
Article VI.	House of Delegates
Article VII.	Districts, Sections and District Societies
Article VIII.	Board of Trustees
Article IX.	Funds and Expenses
Article X.	Referendum
Article XI.	The Seal
Article XII.	Amendments
Article XIII.	Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies, but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, a Vice President, a Secretary, a Treasurer, a Speaker and Vice Speaker of the House of Delegates, a Trustee and an Alternate Trustee from each district that may be established; and such other officers as may be provided for in the Bylaws.

Section 2. The eligibility, duties and terms of office of all officers of the Association shall be as prescribed in the Bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem

appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable, provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications, and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Discipline—The Judicial Council
Chapter VIII. Standing Committees and Councils
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CHAPTER I. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into eight classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Service, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component medical societies. To be eligible for active membership in any component society, the applicant must be a physician who holds an unrestricted or limited license to practice medicine and surgery in this state, and who is of good moral, ethical and professional standing. Nothing contained herein shall prevent a component society from requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component medical societies. To be eligible for associate membership in any component society, the applicant must qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

(3) Osteopathic physicians who practice allopathic medicine.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicinc in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Service Members. Members of the Association in good standing who enter military service and are ineligible for Associate membership shall be classified as service members. Service Members shall not be required to pay dues. If a member in good standing enters service prior to April 1 and has paid his dues for that year, he shall receive all publications and other benefits applicable to his class of membership in the Association and shall owe no further dues until January 1 following his release. If a member in good standing enters service prior to April 1 without paying his dues for that year, he shall receive publications and other benefits but shall owe the dues applicable to his class of membership immediately following his release from active duty. Members whose dues have not been received by April 1 are not in good standing.

(g) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(h) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society, provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. No person who is finally convicted of a felony subsequent to September 26, 1968, shall be eligible for membership in this Association unless and until, upon proper application to the Judicial Council, it is determined that he is morally and ethically qualified. Except as provided in Chapter VII, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association shall be entitled to any of the rights or benefits of membership of this Association.

Section 5. Every new member shall be required to attend and successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board; and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within three years after the member is first admitted to active membership shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member; and he shall thereafter, for a period of one year, be ineligible for membership in any component society and shall not after one year be admitted to membership unless and until he has successfully completed the required orientation course.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or such officers as the Board of Trustees may direct. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. The members of the House of Delegates shall be elected by the various component societies in the manner prescribed in Chapter XII of these Bylaws.

Section 6. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 7. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 8. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 9. No resolution shall be introduced in the first meeting of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven days prior to its introduction. The only exception to this shall be that a resolution which has been signed by ten or more members of the House of Delegates and of which there are sufficient printed copies to distribute to each member of the House of Delegates may be received for consideration by an affirmative vote of three-fourths of the members present and voting. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 10. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 11. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 12. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 13. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 14. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 15. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 16. The state shall be divided into the following districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 17. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 18. Except as provided in Chapter VI, Section 4, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 19. A digest of proceedings of the House of Delegates shall be published and distributed to the membership annually.

CHAPTER IV. ELECTION OF OFFICERS AND DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Section 1. The President-Elect and the Vice President shall be elected for a term of one year, the President-Elect succeeding to the presidency at the expiration of his term as President-Elect. The Vice President shall be elected from the same general area in which the president resides. Delegates to the AMA and their alternates shall be elected for terms of two years. The Speaker of the House of Delegates, the Vice Speaker, the Secretary, and the Treasurer shall be elected for terms of three years, but no member shall be eligible for election to more than two consecutive full terms as Secretary or Treasurer. Trustees and their Alternates shall be elected for terms of three years and Trustees shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees and their Alternates shall coincide and be so arranged that one-third of the terms expire each year, insofar as possible, provided, however, that nothing contained herein shall preclude an Alternate Trustee from serving two full terms as a Trustee. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, Trustee or Alternate Trustee who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the Nominating Committee for the next year. The five names receiving the most votes shall form the committee. The committee shall select one of its members as chairman at an organization meeting held during the Interim Meeting, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the committee shall have a hearing. Before noon of the following day, the committee shall post on a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussion or comment. Vacancies occurring on the Nominating Committee by virtue of death, resignation, or disability, shall be filled by appointment of the Speaker.

Section 3. The election of officers and delegates to the AMA and their alternates shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District form the Nominating Committee for the purpose of nominating a Trustee and an Alternate Trustee for the District concerned. This committee shall hold a well-publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting for the purpose of discussing the nomination of the Trustee and his Alternate to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit or cause to be visited on his behalf, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice President shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President shall succeed to the office of the President.

Section 4. The President-Elect and the Vice-President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Director in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Director and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice-President, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the Vice President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the authority to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press.

Section 5. The Journal of the Kentucky Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the Alternate Trustee shall succeed to the office of Trustee. In case of disability, the Alternate shall serve until the disability

is removed or the Trustee's term expires, and in the absence of the Trustee, the Alternate Trustee shall vote in his place and stead.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Director whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Director shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall, within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a record of all physicians in the State by counties, noting on each his status in relation to his county society, and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor, or otherwise supervise the publication of *The Journal of the Kentucky Medical Association* and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary, shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

Upon the complaint of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustees for a determination as to whether probable cases for disciplinary action exist. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent, and a representative

of the Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.

In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable the Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recomendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

CHAPTER VIII. COMMITTEES AND COMMISSIONS

Section 1. The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications and public service, and governmental medical services.

Section 2. The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

Section 3. The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary, ad hoc committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

Section 4. No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members $130, except that the dues for new members entering practice for the first time shall be $80 per year for the first three full years of practice; (2) Emeritus Members, no dues; (3) Associate Members, $10; (4) Inactive Members, $10; (5) Student Members, $1; (6) Service Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessments together with its properly classified roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January each year.

Section 2. Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 3 of this Chapter, all county medical societies in this State which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 4. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Two or more adjacent component societies may also combine into one multi-county component society by adopting resolutions to that effect at special meetings called for that purpose on at least ten days' notice. Copies of the resolutions, certified as to their adoption by the Secretary of each society, shall be forwarded to the Headquarters Office. If approved by the Board of Trustees, the multi-county society shall thereupon be issued a charter, the consolidating county societies shall cease to exist and the multi-county society shall become a component society of this Association; provided, however, that the active members residing in each county comprising the multi-county society shall be entitled to elect a delegate or delegates to the House of Delegates, as if each such county constituted a component society within the meaning of Section 12 of this Chapter; and provided, further, that multi-county societies may elect, at large, one alternate delegate for each delegate to which it is entitled under this section and such alternate may serve in the absence of the delegate for whom he is the designated alternate.

Section 5. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association and shall be classified in accordance with Chapter I, Section 2 of these Bylaws, provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 6. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 7. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 8. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 9. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days, appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of

the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership, provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 10. Frequent meetings shall be encouraged and the most attractive programs arranged that are possible. Members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 11. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session, provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25, provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of delegates as its component societies would have had. The secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 12. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

CHAPTER XIII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day, provided, however, that an amendment may be proposed in the report of a reference committee and considered by the House without having laid on the table for one day.

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Founded 1904

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Contact: (1) Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

(2) Samuel N. Workman, M.D.
Chief of Clinical Services

(3) Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry
and Medical Director

Area Code 704-254-3201

KMA Committees and Commissions for the 1970-71 Associational Year

ANNUAL MEETING ACTIVITIES

Scientific Program Committee

Allan M. Lansing,M.D ., Louisville, Chairman
Ralph M. Denham, M.D., Louisville
R. Glenn Greene, M.D. Owensboro
John S. Harter, M.D., Louisville
James W. Hollingsworth, M.D., Lexington
John C. Quertermous, M.D., Murray
J. Sankey Williams, M.D., Nicholasville

Scientific Exhibits Committee

Benjamin B. Jackson, M.D., Louisville, Chairman
Marvin Murray, M.D., Louisville
Arnold C. Williams, M.D., Lexington
Jonathan D. Wirtschafter, M.D., Lexington

Awards Commitee

Douglas E. Scott, M.D., Lexington, Chairman
William H. Bizot, M.D., Louisville
Sam A. Overstreet, M.D., Louisville
W. Vinson Pierce, M.D., Covington
Clyde C. Sparks, M.D., Ashland

MEDICAL EDUCATION AND HOSPITALS

Committee on Medical Education

Walter I. Hume, Jr., M.D., Louisville, Chairman
Douglas M. Haynes, M.D., Louisville
William S. Jordan, Jr., M.D., Lexington
David W. Kinnaird, M.D., Louisville
Frank R. Lemon, M.D., Lexington
Elmer G. Prewitt, M.D., Corbin
Myron G. Sandifer, M.D., Lexington
Carl H. Scott, M.D., Lexington
William J. Temple, M.D., Covington

SAMA Representatives

University of Louisville—Hoyt D. Gardner, M.D., Louisville
University of Kentucky—Donald Edger, M.D., Lexington

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman
Clyde M. Brassfield, M.D., Elizabethtown
Royce E. Dawson, M.D., Owensboro
Lewis Dickinson, M.D., Glasgow
James L. Ferrell, M.D., Paris
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From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 2-69. This twenty-three year-old married, white, gravida 2, para 1 was seen by a physician January 9, 1969, with the chief complaint of vomiting. She was treated and improved. She visited another physician January 30, 1969, complaining of malaise. Physical examination was essentially negative. Blood count and urinalysis were done and were within normal limits. The hemotocrit was 43% and the specific gravity of urine was 1.005. She denied missing any menstrual periods. One thousand ml of dextrose in water was administered intravenously in the office and a prescription for Phenergan rectal suppositories and oral Libritabs were given. The following day she was feeling much better, but still a little weak. She was taking fluids and was able to eat. The vomiting had stopped.

The patient came to the office February 4 complaining of headache. She stated she had been vomiting since last evening. There were no other complaints and she stated she had been taking the medication as directed. Intravenous fluids were again given in the office, and 25 mg Phenergan IM. She became somnolent, however; when awakened she would talk, then drop back to sleep. Once during this time she tried to go to the bathroom but fainted; however, when returned to bed she responded. The possibility of hospitalization was discussed. Her husband claimed this would be difficult financially. He requested that she be given until the next morning, to see if improvement occurred as previously. Her pulse was slow, regular, and strong. Lungs were clear. The patient was then taken home. Thirty minutes later the family called and requested an immediate house call. When the physician arrived, the patient was found dead lying on her back in bed. She had been convulsing.

An autopsy was obtained. There was evidence of electrolyte imbalance. There was aspiration material in both lungs. Acute congestion of the cerebral vessels and petechial hemorrhages of the gastric mucosa were present. The kidneys gave evidence of an early toxic mephrosis and glomerulonephritis. There was a fetus measuring 1.8 cm crown-heel length in the uterus with an intact immature placenta.

The final diagnosis was electrolyte imbalance from hyperemesis gravidarum with aspiration of the vomitus—early intrauterine pregnancy.

Comment

The Committee classified this maternal death as a direct obstetrical one, with preventable factors on the part of the patient. Death from hyperemesis gravidarum, as well as termination of pregnancy to relieve the condition, should not occur today. From the data presented, the physician properly cared for this patient.

Nausea in pregnancy has been listed as the most frequent complaint during gestation. However, with the advent of numerous drugs and an understanding of this condition, it can be successfully treated. Previously pernicious vomiting of pregnancy could be lethal. It can be associated with severe hepatic lesions. There is profound necrosis of the central portion of the lobules, with the periphery remaining intact. The destruction of liver tissues can greatly compromise hepatic function. In other cases that are fatal, the liver undergoes a marked fatty degeneration, with the characteristic necrosis absent. These lesions can be explained by starvation and are unrelated to the etiology of the vomiting. The renal lesions are those of degeneration and are practically always limited to the convoluted tubules. The epithelium, in many cases, will be necrotic and the lumen of the tubules filled with debris. Persistent vomiting can be present for weeks and the patient become emaciated before the seriousness of the condition is appreciated. The late stages of the disease are hardly ever seen today. A low grade fever may frequently develop, as well as jaundice and coma. Eastman and Helman[1] list five signs as grave omens which, when several are present, would lead one to therapeutic abortion: (1) jaundice, (2) delirium, (3) steady rise in pulse rate to 130 or above, (4) fever of 101° F or above that persists despite liberal intake of fluids, and (5) hemorrhages in the retina.

With the above knowledge in mind the Committee questions whether this maternal death was one due to pernicious vomiting during pregnancy. Although it was not revealed by the autopsy examination, the Committee raised the question of whether some poison or underlying severe renal disease was present that caused this woman's death. Perhaps a search for a toxic material would have been fruitful; for a toxic nephrosis may result from poisoning by heavy metals, therapy with anticonvulsant drugs, and allergies to poison ivy, Bee or Wasp venom. The terminal event appeared to be a convulsion leading to aspiration of vomitus. It would seem that such a factor led to her demise. It was with these thoughts that the Committee rendered the decision that there were preventable factors attributable to the patient, or perhaps her husband.

References

1. Eastman, N. J., and Hellman, L. M., Williams, *Obstetrics* 13th Edition, Appleton-Century Crofts, page 685.



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Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo. .. ½ tsp.* t.i.d. (3 mg.)
6-12 mo. .. ½ tsp. q.i.d. (4 mg.)
1-2 yr. ... ½ tsp. 5 times daily (5 mg.)
2-5 yr. ... 1 tsp. t.i.d. (6 mg.)
5-8 yr. ... 1 tsp. q.i.d. (8 mg.)
8-12 yr. .. 1 tsp. 5 times daily (10 mg.)
Adults: ... 2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.
*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

953

G. D. SEARLE & CO. • P.O. Box 5110, Chicago, Illinois 60680 • Research in the Service of Medicine

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

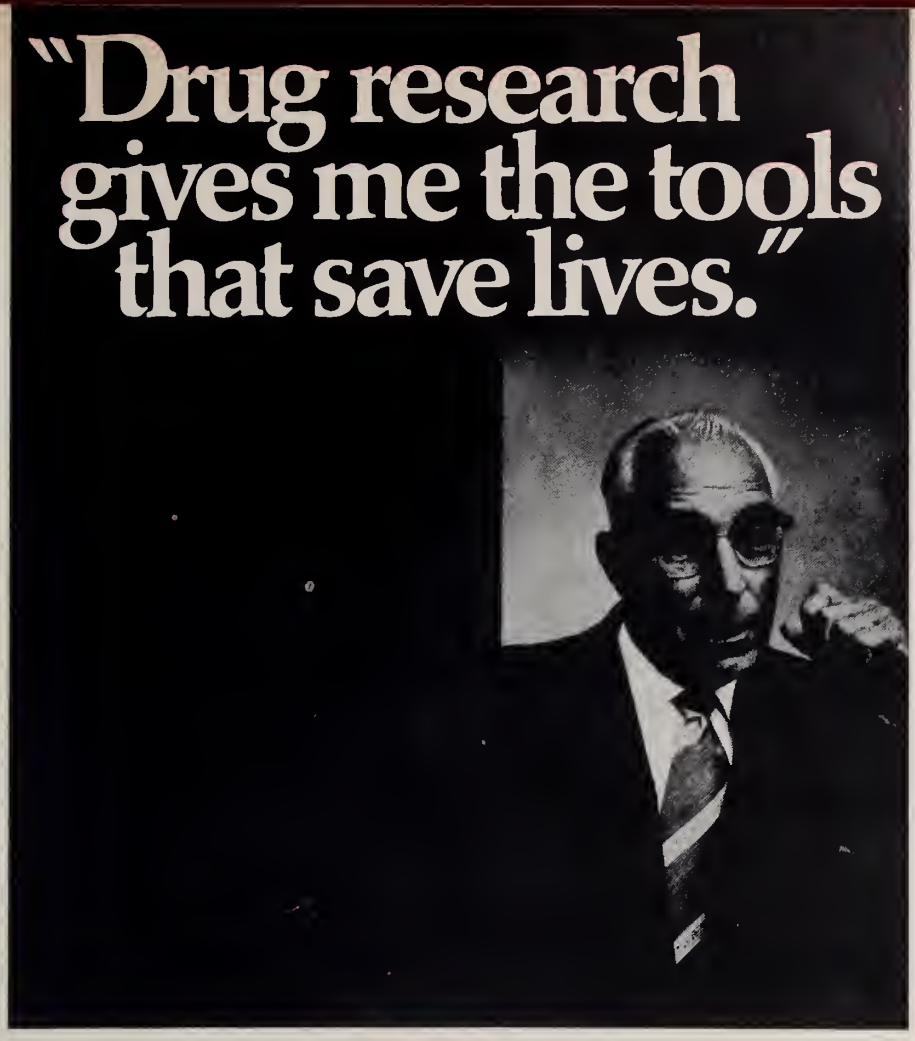
Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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Smith Kline & French Laboratories

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A family doctor looks at new developments in the pharmaceutical industry. And he speculates on the future.

When I look back at some of my old records, I'm constantly reminded of the changes that have come about in medicine just during the past twenty-five years. Some of the diseases I treated and prayed over in the '40's are found mostly in medical history books now.

Thanks to drug research and development, we've made substantial gains in the control of cardiovascular disease, diabetes, malaria, mental illness, strep and staph infections, meningitis and a long list of ailments. It seems like only yesterday when a diagnosis of pneumonia was almost the kiss of death. Now, with modern medical techniques and drug therapy, we can offer some real help.

My records on polio, influenza and measles show an unbelievable trend for the better. New vaccines have reduced the toll of these age-old threats dramatically. And I see patients in pain from crippling arthritis helped with new medicinals unknown just a few years ago.

I hear questions about the three billion or so dollars spent by the drug industry in research during the past ten years . . . working on new and better drug products. It does seem like quite a bit of money to spend, and I realize some of it goes into dead ends. That's the problem with research, any research . . . you often don't know where you're going until you get there. I want all the tools I can get to help my patients. I want more drugs and more effective drugs. If they mean less pain, longer lives and more productive careers for those I treat . . . well, that's what really counts.

Another point of view . . .
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Roche announces

Efudex®

(fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex®(fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



2/2/68—After 11 days of treatment. Erythema is seen at site of keratoses. In addition, numerous lesions not apparent prior to therapy have become manifest by sharply defined reactions. Intervening skin, also treated, shows no response to therapy.

2/19/69—One year after cessation of therapy. Skin appears clear with no evidence of scarring. Examination reveals lack of recurrence or the formation of new lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new Efudex® (fluorouracil) cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

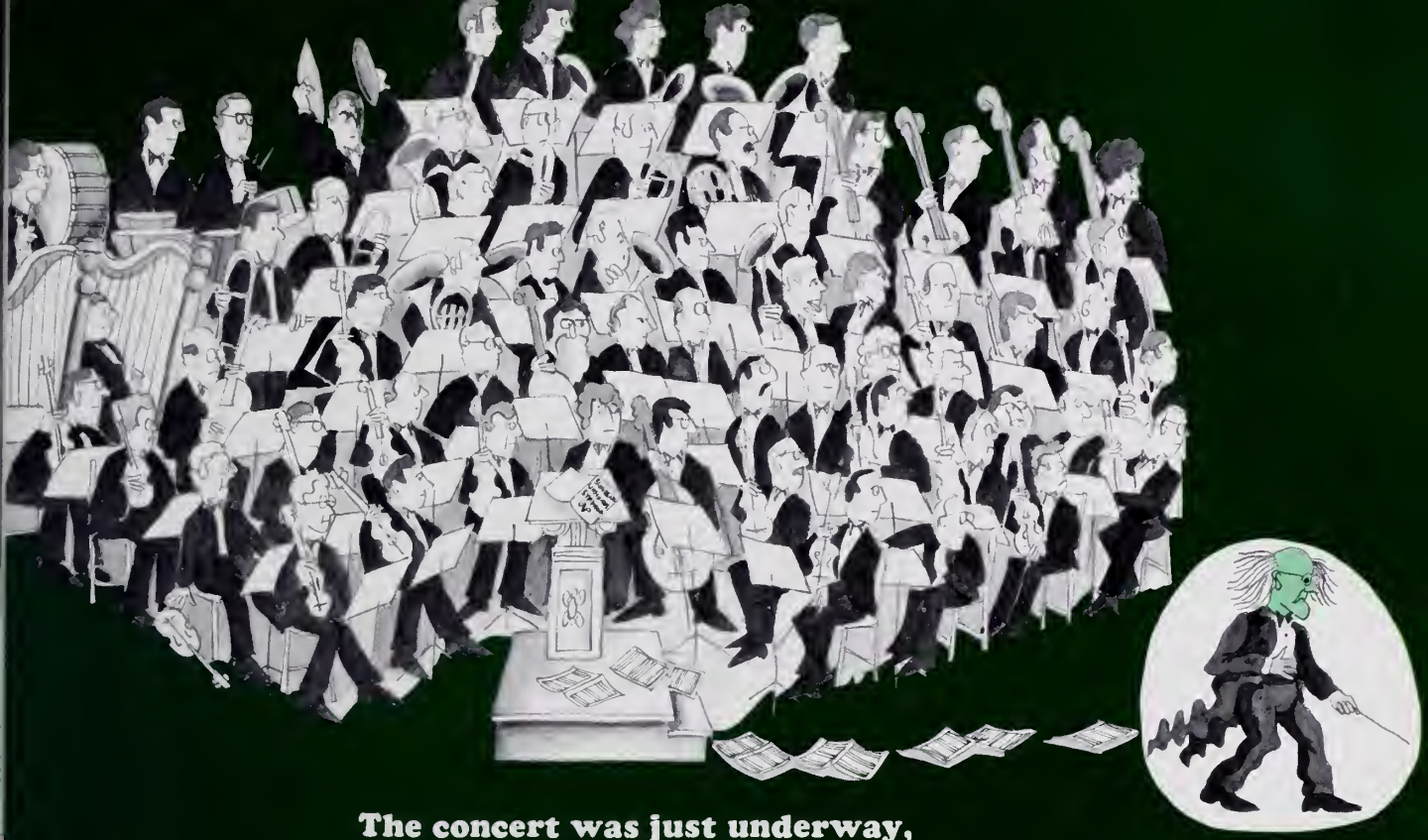
Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions where complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

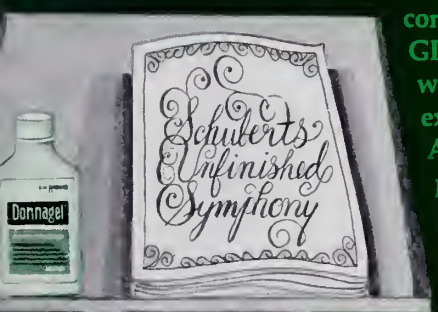
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Nutley, New Jersey 07110



The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can strike at the most inopportune time, it takes a comprehensive agent to treat the total diarrheal syndrome and help get the patient back on the job. That's why so many physicians rely on Donnagel, especially during the fall and winter months when "flu" and viral gastroenteritis usually hit their peak.

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Each fluid ounce contains: Kaolin, 6 g.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Sodium benzoate (preservative), 60 mg.; Alcohol, 3.8%.

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clear the tract with the

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Codeine phosphate	10.0 mg.
(warning: may be habit forming)	
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Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Dextromethorphan hydrobromide	15.0 mg.
Alcohol, 1.4%	

Clears sinuses and nasal stuffiness as it relieves cough

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Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Phenylephrine hydrochloride	10.0 mg.
Alcohol, 1.4%	

Robitussin-DM in solid form for "coughs on the go"

Cough Calmers™

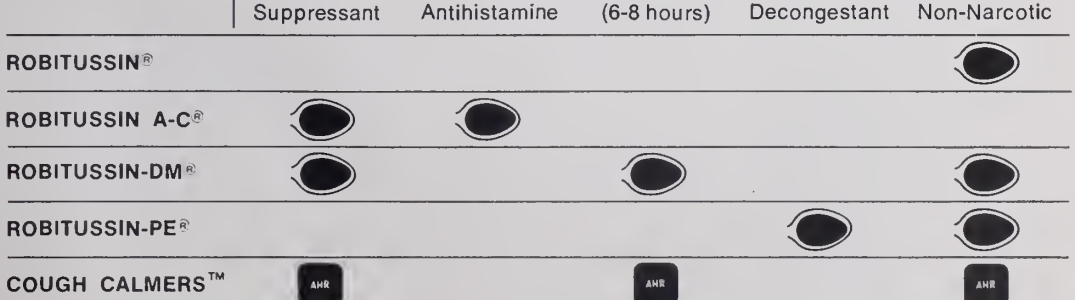
Each Cough Calmer contains:

Glyceryl guaiacolate	50.0 mg.
Dextromethorphan hydrobromide	7.5 mg.

Select the Robitussin® "Clear-Tract" Formulation That Treats Your Patient's Individual Coughing Needs:

Robitussin® extra benefit chart

All 5 Robitussins have an EXPECTORANT-DEMULCENT action. Keep this handy chart as a guide in selecting the formula that provides the *extra* benefits you want for your patient.



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and Walter I. Hume, Jr., M.D.

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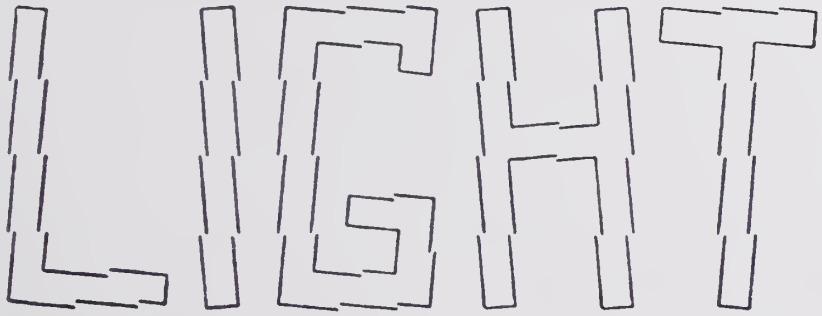
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